Fact Sheets

of the
Department of Alcohol and Drug Programs

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STATE OF CALIFORNIA
DEPARTMENT OF
ALCOHOL AND DRUG PROGRAMS

Department of Alcohol and Drug Programs Fact Sheets
Part II

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March 1998

Fact Sheet:

Drug/Medi-Cal Cost Containment Measures and Outcomes

Legislative History and Authority

The Fiscal Year (FY) 1995-96 Budget Act directed the Department of Alcohol and Drug Programs (ADP) to implement cost containment strategies and effectively address the rising costs of the Drug/Medi-Cal (D/MC) program. In order to contain costs, a new section (14132.90) was added to the Welfare and Institutions Code. This section required that, if expenditures for D/MC exceeded $60 million in State General Fund (SGF) in FY 1995-96, the outpatient drug-free benefit will be eliminated in FY 1996-97.

In response to the Budget Act directives, ADP implemented several changes to effect cost containment in the areas of D/MC eligibility, benefits, rates and utilization. The measures taken in these areas have proven effective at containing projected SGF costs in FY 1995-96 from an estimated $47 million to an actual statewide budgeted amount of $28,203,805.

Building on the success of cost containment in FY 1995-96 and to provide for the management of D/MC program growth and costs, the Budget Act for FY 1996-97 instituted additional measures. Among these measures was the reduction of the trigger from $60 million to $45 million. The Budget Act for FY 1997-98 continues the trigger amount at 45 million. Preliminary budgeted amounts for the D/MC Program for FY 1997-98 indicate that $32.5 million is the planned SGF expenditure amount.

Benefits

- Continues the restriction that only pregnant women and women within the 60-day postpartum period are eligible for day care habilitative and perinatal residential services. Previously, parenting women had been included.
- The scope of benefits remain the same as FY 1996-97, however the NTP services, now include LAAM and methadone as medication options, pursuant to AB 2071.

Rates

- Separate maximum allowable reimbursement rates have been established for regular D/MC services and perinatal enhanced D/MC services.
- The group counseling rate for outpatient drug-free programs is set at a maximum of $20 per D/MC beneficiary.
- Rates of reimbursement for AOD services have been surveyed, analyzed and validated by an independent actuarial firm, the Mercer Group.
- Fixed rates for D/MC NTP services have been established, pursuant to AB 2071.

Cost Containment Achieves Results!

As previously mentioned, the cost containment efforts first begun in FY 1996-97 resulted in statewide budgeted SGF amount for D/MC services of less than $30 million, well within the $60 million allowed by the trigger provision, and retained ODF services as a D/MC benefit. The reduction of the allowable SGF expenditure for D/MC services from $60 million to $45 million means that in FY 1996-97 an additional $15 million SGF is available for planned funding of non D/MC treatment and prevention services.

The ADP cost containment and managed care committees continue their review and analysis of cost containment strategies, and issue recommendations for further action, as necessary. ❐

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March 1998

Fact Sheet:

Drug / Medi-Cal Direct Contracts

FY 97/98 Direct Contracts

The Department currently contracts with ten providers in eight counties (Alameda, Butte, Imperial, Orange, San Diego, San Luis Obispo, Stanislaus and Sutter/Yuba). Over $5.5 million is allocated to these direct contracts.

Authority

As a result of the class action lawsuit, ***Sobky v. Smoley***, on August 22, 1994, an **Order for Permanent Injunction** was filed that mandated the State to implement specific court orders related to alcohol and drug Medi-Cal services (Drug/Medi-Cal).

Prior to the lawsuit, counties could decide which providers would be certified to participate in Drug/Medi-Cal (D/MC) and the maximum amount of their funding. As a result of the litigation, any provider may apply for certification and, if it meets the standards, may bill D/MC services for eligible beneficiaries and determine the number of beneficiaries it wishes to serve. Counties may retain their roles as administrators of all D/MC services, but they are now required to contract with all certified providers who wish to bill Drug/Medi-Cal. If a county decides to not be an agent of the State and administer the D/MC Program in its county, the State must contract directly with certified providers within the county. The State retains all or part of the county's State General Fund (SGF) to contract directly with the private providers. The State's administrative cost of utilization review is also charged against a county's SGF allocation.

While the Department prefers that the County maintain its administrative role in D/MC services, the State is prepared to accept the direct contract responsibility whenever necessary.

Direct Contract Process

Immediately upon learning of the need for a direct contract, the State contacts the provider and requests a proposed budget for the time period needed. Most direct contracts are for the entire fiscal year; however, for newly certified providers, the contract date is the date of certification through the end of the fiscal year. Also, counties that wish to initiate a contract with providers directly contracting with the State will have an opportunity to retransition the contracts at one point in the fiscal year.

Contract budgets are reviewed for accuracy and appropriateness and, if approved, forwarded to the Department's Contract Unit for processing. The contract is then sent to the provider for review and sign off and returned to the Department. A copy of the fully executed contract is mailed to the provider and claims against the contract can then be processed for payment. ❐

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Fact Sheet:

Drug / Medi-Cal Issues and Legal Authority

STATEWIDE APPLICATION

The California State Plan for Medicaid shall be in effect in all political subdivisions of the State, and if administered by them, the Plan must be mandatory upon those political subdivisions.

Sobky v. Smoley,
42 USC[1] §1396a(a)(1)
42 CFR[2] §431.5(b)

PROVIDER CERTIFICATION REQUIRED

Each provider must be certified to participate as a provider in the D/MC system.

42 CFR §431.107
43 CFR Part 442, Subparts A and B (if applicable)
42 CFR §442.12(d)
WIC[3] §14123

BENEFICIARY FREEDOM OF CHOICE

A Medi-Cal beneficiary may choose services from any institution, agency, or person certified to perform the service.

42 USC §139a(a)(23)
42 CFR §431.51(a)(1)

REASONABLE PROMPTNESS

Services shall be furnished to all eligible individuals with reasonable promptness.

Sobky v. Smoley,
42 USC §139a(a)(8)
42 CFR §435.930

NO BUDGETARY CONSTRAINTS ON BENEFITS

Benefits made available to one beneficiary shall be no less in amount, duration, or scope than the benefits made available to any other beneficiary.

Sobky v. Smoley,
42 USC §1396a(a)(10)(B)
42 CFR §440.240

STATE GENERAL FUND USE FOR D/MC

The State General Fund provides funding for the State's share of expenditures for D/MC services.

Budget Act, Chapter 282
Statutes of 1997

D/MC BENEFITS

D/MC benefits are optional Medi-Cal benefits as contained in the California State Plan for Medicaid. Services include: Narcotic Treatment Program, Outpatient Drug Free, Day Care Habilitation, Naltrexone, and Perinatal Residential services.

22 CCR[4] §51341.1(d)

RATES

D/MC maximum rates are developed by ADP and set annually by the Department of Health Services. A provider may bill for actual costs up to the maximum allowances established for the FY. Rates for FY 1997-98 were set in the Budget Act of 1997. Claims submitted for services provided on or after July 1, 1996 must not exceed the new maximum rates.

22 CCR §51516.1
WIC § 14021.5(e) & 14021.6
Budget Act, Chapter 282,
Statutes of 1997

RATE-SETTING METHODOLOGY

Maximum allowable rates for D/MC are determined by computing the median rate from available cost data, by modality, from the fiscal year that is two years prior to the year for which the rate is being established.

22 CCR §51516.1
42 CFR §413.30(b)
WIC §14021.6(a)

[1] USC.....United States Code
[2] CFR.....Code of Federal Regulations
[3] WIC.....Welfare and Institutions Code
[4] CCR.....California Code of Regulations

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March 1998

Fact Sheet:

Drug / Medi-Cal Monitoring

The Interagency Agreement (IA) between the Department of Health Services and the Department of Alcohol and Drug Programs (ADP) requires all Drug Medi-Cal (D/MC) programs to be subject to utilization review and control. Authority governing utilization controls is provided in the Federal Medicaid Law (42 USC 1396(a)(30-33) and Federal Medicaid Regulations, Title 42, Code of Federal Regulations, Sections 456.2 through 456.6.

Utilization review provides certain safeguards against unnecessary services in substance abuse programs providing D/MC services. ADP has promulgated regulations in Title 22 of the California Code of Regulations detailing the minimum requirements for D/MC. The Title 22 regulations define the roles and responsibilities of ADP, the county, and the provider. Effective July 1, 1997, the Title 22 regulations require that ADP conduct postservice, postpayment utilization reviews for compliance with standards of care and other requirements of the regulations. This process is intended to provide statewide quality assurance and accountability for D/MC services.

State Role

ADP is responsible for administrative and fiscal oversight, monitoring, and auditing to safeguard California's investment in D/MC alcohol and drug treatment services. This is accomplished through the promulgation of the Title 22 D/MC regulations and on-site visits to D/MC providers by the staff of ADP.

The purpose of these visits is to ensure that D/MC compliance measures are in place for each provider participating in the D/MC program, to provide technical assistance and training to provider staff, and to initiate the recovery of payments process when D/MC requirements have not been met.

A written report is issued at the conclusion of each on-site visit, detailing the deficiencies found. The county and/or provider are required to develop and implement a written plan of corrective action for every deficiency contained in the report.

County Role

The county is responsible for contracting with the providers, if applicable; implementing and maintaining a system of fiscal disbursements and controls; monitoring the billings to ensure that reimbursement is within the rates established for services; and processing claims for reimbursement.

Provider Role

All D/MC providers must be certified to participate in the D/MC treatment service system and must comply with all D/MC requirements. This includes, at a minimum, identifying the DSM diagnostic code; establishing the medical necessity for treatment; following D/MC admission criteria and procedures; developing and updating treatment plans; preparing progress notes; providing counseling; justifying the need to continue services; and completing a discharge summary.

Outcomes

ADP monitoring and auditing of D/MC services results in quality control in the provision of publicly funded treatment, assists counties and providers in identifying and resolving compliance issues, and provides an opportunity to render training and technical assistance to counties and providers. ❐

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March 1998

Fact Sheet:

Drug / Medi-Cal Rates for Fiscal Year 1997-98

Description	Service Function Code	Unit of Service (UOS)	Program 20 (Alcohol/Drug Services) UOS Daily Rate (*)	Program 25 (Perinatal) UOS Daily Rate (*)	Fixed Rate or Exact Maximum Allowance Rate
NTP — Methadone Maintenance (OMM)	20, 21, and 22	Daily	$5.66 (**)	$6.57 (**)	Fixed Rate
NTP — Levoalphacethlmethadol (LAAM)	23, 24, and 25	Daily	$5.66 (**)	$6.57 (**)	Fixed Rate
NTP — Individual Counseling (***)	26, 27	One 10-minute increment	$10.53	$14.82	Fixed Rate
NTP — Group Counseling (***)	28, 29	One 10-minute increment	$3.61	$5.08	Fixed Rate
Day Care Habilitative (DCH)	30 through 39	Face-to-Face Visit	$65.95	$80.83	Maximum Allowance Rate
Perinatal Residential (RES)	40 through 49	Daily	NOT APPLICABLE	$70.87	Maximum Allowance Rate
Naltrexone (NAL)	50 through 59	Face-to-Face Visit	$21.20	NOT APPLICABLE	Maximum Allowance Rate
Outpatient Drug Free (ODF)— Individual Counseling	80 through 84	Face-to-Face Visit (Per Person)	$52.67	$74.11	Maximum Allowance Rate
ODF - Group Counseling	85 through 89	Face-to-Face Visit (Per Person)	$32.50	$45.73	Maximum Allowance Rate

* *These are effective July 1, 1997.*

** *The combined daily rates for core, lab work and dosing include $0.54 for non-perinatal services and $0.62 for perinatal services for the county or ADP when ADP assumes the role of the county. Provider claims shall be adjusted to reimburse the county or ADP for administrative costs.*

*** *ADP shall reimburse Narcotic Treatment Program (NTP) providers up to 200 minutes (20 ten-minute increments) of individual and/or group counseling per calendar month, per beneficiary.* ❐

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January 1995

Fact Sheet:

Driving Under the Influence (DUI)

Driving under the influence is a serious problem involving not only the impaired driver, but all others who share the roadway.

1993 National DUI Statistics

People (Drivers, Passengers, Pedestrians)

- 40,115 people were killed in 29,981 traffic crashes. 17,461 of these fatalities were a result of alcohol; this represents an average of one alcohol-related fatality every 30 minutes.
- About 289,000 persons suffered injuries in alcohol-related crashes. This is an average of one person every 2 minutes.
- In 1993, forty percent of pedestrians (16 years and older) killed in nighttime crashes had blood alcohol concentration levels at .10 percent or more.
- Motor vehicle crashes are the greatest single cause of death for every age between the ages of 5 and 32. Almost half of these fatalities are a result of alcohol.

Drivers

- 12,049 drivers were fatally injured in single-vehicle crashes. About 52.5 percent were intoxicated.
- More than 1.6 million drivers were arrested for DUI. This is an arrest rate of 1 for every 108 licensed drivers in the United States.
- In 1992, thirty-eight percent of all drivers involved in fatal crashes had estimated blood alcohol concentration levels of .10 percent or higher.

Crashes

- The proportion of fatal crashes that are alcohol-related is about three times greater at night than during the day.
- About two in every five Americans will be involved in an alcohol related crash at some time in their lives.
- Crashes involving men are more likely to be alcohol-related than those involving women. Among fatally injured male drivers, 44 percent had blood alcohol concentration (BAC) levels of .10 percent or more; the percentage for women was 22. Alcohol involvement is highest for men age 25-34.
- The probability of a crash begins to increase significantly at 0.05 percent BAC; for drivers with BACs above 0.15 percent on weekend nights, the likelihood of being killed in a single-vehicle crash is more than 380 times higher than it is for nondrinking drivers.

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Youth

- 33 percent of fatally injured 16-20 year old drivers were intoxicated.
- Teenage drivers with blood alcohol concentrations between 0.05-0.10 percent are far more likely than sober teenage drivers to be killed in single-vehicle crashes—18 times more likely for males and 54 times more likely for females.

Blood Alcohol Concentration (BAC)

- Even at blood alcohol concentration levels as low as .02 percent, alcohol affects driving ability and crash likelihood. The probability of crash begins to increase significantly at .05 percent BAC and climbs rapidly after about .08 percent BAC.
- Three percent of a national sample of drivers on weekend nights had BAC levels at or above .10 percent.

Trends

- Since 1982, the numbers of alcohol-related crashes and fatalities have been slowly decreasing.
- The proportion of drivers 16-20 years of age who were involved in fatal crashes and were intoxicated dropped from 31.1 percent in 1982 to 27 percent in 1993.

California Statistics

July 1992 - June 1993

- Approximately 25 percent of all first time DUI offenders reoffend within five years.
- 26,733 Alcohol-Involved Injury Crashes
- 42,936 Alcohol-Involved Injuries
- 1,389 Alcohol-Involved Fatal Crashes
- 1,569 Alcohol-Involved Fatalities

Trends: 1992-1993

- Alcohol-involved traffic fatalities decreased 10.5 percent in 1992. Although alcohol involvement in traffic accidents has declined over the past 10 years, 44 percent of all traffic fatalities were still alcohol involved.

Blood Alcohol Concentration (BAC)

- The illegal blood alcohol concentration level in California is set at .08 percent. Although it is illegal to operate a motor vehicle with a BAC of .08 percent or higher, the typical arrestee registers more than double the legal limit at the time of arrest.

First Offender	***.16 percent***
Second Offender	***.18 percent***
Third Offender	***.18 percent***
Fourth Plus	***.18 percent***
Average	***.17 percent***

Administrative Drivers License Revocation

- In 1990, California implemented a mandatory drivers license suspension law for drinking drivers, also known as ‘‘admin per se.’’
- 197,000 licenses were suspended as a result of ‘‘admin per se’’ in the period July 1993 through June 1994. ■

Driving Under the Influence / DUI:

The Most Frequently Asked Questions

How serious is the problem?

More than 22,000 lives are lost each year because Americans persist in drinking and driving. The National Highway Traffic Safety Administration estimates that there is an average of one alcohol-related fatality every 30 minutes.

During 1993, about 289,000 persons suffered injuries in alcohol-related crashes. This is an average of one person every 2 minutes. About 96,000 of these were serious injuries.

About two in every five Americans will be involved in an alcohol-related crash at some time in their lives. Traffic crashes are the greatest single cause of death for every age between the ages of 5 and 32. Almost half of these fatalities are a result of alcohol.

How does the DUI problem impact young people?

Drinking and driving continues to be the number one killer of young people. On a per population basis, drivers under the age of 25 had the highest rate of involvement in fatal crashes among all age groups. Intoxication rates for 16-20 year old drivers in fatal crashes in 1993 was 16.2 percent. The highest intoxication rates were for drivers 25-34 (28.5 percent) and 21-24 (30.7 percent).

Trends

Statistics show that alcohol-related crashes and deaths have been slowly decreasing since 1983. In 1993, there were 17,461 alcohol-related fatalities which is a 26 percent reduction from the 23,646 alcohol-related fatalities reported in 1983.

What are the penalties for DUI?

Fines/Penalties
.....approximately $1000 to $2500
Jail/Community Service
.....2 days to 1 year
Alcohol/Drug Treatment Program
.....3, 18, or 30 month programs
Drivers License Suspension
.....4 months to 5 years

How much does a DUI cost?

Costs for DUI have been estimated to be more than $4,500. (Actual costs may vary. This amount does not include attorney fees or lost wages due to court appearances.) Here is a conservative itemized breakdown:

Fines/Penalties	$1,500
Tow/Impound Fee	150
Bail	150
Alcohol Treatment	400
Insurance Increase	1,600
Restitution Fund	500
DMV Reissue Fee	100
Jail Time	100
Total	$4,500

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How much alcohol does it take to impair driving?

This depends on several factors:

- Your weight. It takes less alcohol to become intoxicated if you weigh 120 pounds than if you weigh 180 pounds.
- Whether you are drinking on a full or empty stomach. It takes less time to get intoxicated if you drink on an empty stomach.
- How many drinks you have and their alcohol content.
- How long you have been drinking.
- Whether you are taking any medicines or drugs, which may combine with alcohol to increase the effect of alcohol on your driving ability.

What is blood alcohol concentration (BAC)?

Blood Alcohol Concentration is a measure of the amount of alcohol in the blood stream expressed as a percentage. The illegal BAC level in California is set at .08 percent. A person weighing 150 pounds, drinking at the rate of 1.5 ounces of alcohol (the approximate amount found in one 12-ounce can of beer or one glass of wine) per half hour, would need:

Two drinks.....to reach a BAC of .05%
Three drinks.....to reach a BAC of nearly .08%
Four drinks .....to reach a BAC of .10%
Six drinks.....to reach a BAC of .15%

Is it safe to drive after drinking modest amounts of alcohol?

Just a drink or two can make someone behind the wheel a threat to themselves and to others. Drinking alcohol affects a driver's coordination, reaction time. and vision (particularly at night.) Long before any outward signs of impairment are recognized, the driver's judgment, emotions, and confidence are adversely effected. Even at BACs as low as .02 percent, alcohol affects driving ability and crash likelihood. The probability of crash begins to increase significantly at .05 percent BAC and climbs rapidly after about .08 percent BAC.

What is "Admin per se?"

''Admin per se'' refers to a relatively new procedure—administrative license suspensions—in which a driver's license may be taken before conviction when a driver fails or refuses to take a chemical test for alcohol. As of July 1994, 39 states including California had administrative license suspension laws. In California a driver's license is suspended for four months on a first offense, and one year for a second offense.

When do most DUIs occur?

Most DUIs occur at night (9 p.m. to 6 a.m.). Sixty-nine percent of the drivers of nighttime single vehicle fatal crashes had BAC levels of .10 percent or more. Only 21 percent had no alcohol in their blood. ■

January 1995

Fact Sheet:

An Overview of California's Driving-Under-the-Influence Program

OVERVIEW

The objective of the DUI program is to: (1) reduce the number of repeat DUI offenses by persons who complete a state-licensed DUI program; and (2) provide participants an opportunity to address problems related to the use of alcohol and/or other drugs.

HISTORY

Legislation was enacted in 1978 that allowed statewide implementation of programs for multiple DUI offenders. Beginning in 1980, there was a considerable legislative effort to ''get tough'' on individuals who drive while under the influence. While the laws to increase fines, limit plea bargaining, provide driver's license restrictions and mandatory jail sentencing became more strict, the need to expand, formalize and standardize DUI program requirements also existed. In 1990, the state was authorized to license programs of at least three months duration for first offenders. Approximately 125,000 people participated in California's DUI programs in fiscal year 1992-93.

PROGRAM DEVELOPMENT AND RESPONSIBILITY

The county board of supervisors, in concert with the county alcohol program administrators determines the need for DUI program services and recommends applicants to the State for licensure. The Department of Alcohol and Drug Programs (ADP) licenses programs, establishes regulations, approves participant fees and fee schedules, and provides DUI information.

FIRST OFFENDER PROGRAMS

A person participating in a program as a result of a first DUI offense must successfully complete a state-licensed three-month, 30-hour alcohol and drug education and counseling program. The programs are designed to enable participants to consider attitudes and behavior, to support positive changes in their lifestyle, and to reduce or eliminate use of alcohol and/or drugs.

18-MONTH PROGRAMS

Second and subsequent DUI offenders must attend the program for at least 18 months. While in the program, participants must complete:

- 52 hours of group counseling;
- 12 hours of alcohol and drug educational sessions;
- 6 hours of community reentry monitoring; and
- 15 minute individual interviews every other calendar week during the first year of the program.

30-MONTH PROGRAMS

A county may elect to provide 30 month DUI program services for third and subsequent DUI offenders. Only Los Angeles County has these services available. While in the program, participants must complete:

- 78 hours of group counseling;
- 12 hours of alcohol and drug educational sessions;
- 120 - 300 hours of community service; and
- close and regular individual interviews. ■

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California's Driving-Under-the-Influence Program: The Most Frequently Asked Questions

What is California doing to address the problem of drinking and driving?

State law requires that a person convicted of DUI be referred to a State-licensed DUI program. The program must successfully be completed before a driver's license is restored.

How does a DUI Program reduce DUI behavior?

A combination of alcohol and drug education and counseling activities helps participants face their unacceptable behavior, determine the level of their involvement with alcohol or drugs, learn alternative ways to deal with alcohol or drugs, and be made aware of the consequences of continued alcohol or drug use, particularly DUI.

Do these programs really work?

A recent study (Peck, R. C., The General and Specific Deterrent Effects of DUI Sanctions, 1991) by the California Department of Motor Vehicles (DMV) concludes that DUI programs are effective in reducing repeated occurrences of DUI. DMV is currently conducting a five-year study to further evaluate the effectiveness of all types of DUI programs in California.

What types of DUI Programs are there?

California has three alcohol and drug education and counseling programs for individuals who have had a DUI offense—a three-month first offender program, an 18-month program for second or subsequent offenders and a 30-month program for third and subsequent offenders. Thirty-month DUI program services are only available in Los Angeles County. In fiscal year 1992-93, approximately 125,000 people enrolled in DUI programs—90,088 people enrolled in first offender programs, 34,489 in 18-month programs, and 252 in 30-month programs.

How much does it cost to participate in these programs?

The cost for participation in a DUI program varies depending upon program location, economic factors and a participant's ability to pay. In September 1992, the average cost was:

first offender program $373

18-month program $1,087

30-month program $2,131

Though it has been the intent of the Legislature that the programs be self-supporting through participant fees, no program participant can be denied services due to the inability to pay the fee.

What is the cost to the California taxpayer?

There is no cost to the taxpayer since participants pay fees which support the cost of the program including the administrative costs of county and State oversight efforts.

February 1997

Fact Sheet:

Environmental Prevention

Overview

The focus of environmental prevention is on altering settings and conditions in which alcohol, tobacco, and other drugs (ATOD) are related to problem behaviors. Environmental prevention considers the system rather than just isolated parts or persons. It complements other prevention strategies operating in the fields of education, medicine, and law enforcement which focus primarily on individuals. Since the late 1980's, the Department of Alcohol and Drug Programs (ADP) has sponsored research and development of this approach.

The goal of environmental prevention is to effectively reduce economic, interpersonal, and social costs imposed on a community, neighborhood, organization, family, or employer due to ATOD-related problems. Within ADP, the CMI Division contracted to publish *The Community Action Manual for the Prevention of Alcohol and Other Drug Problems* to assist communities in addressing these issues. This guide for community-level initiatives describes steps to establish public policies and specific programs to prevent problems on behalf of the larger community.

Process

Environmental prevention makes use of the public health model in defining and addressing ATOD-related problems. Emerging from the public health field, this model is concerned with describing ATOD-related problems in terms of relationships between three entities: the *agent*, the *host*, and the *environment*. The *agent* is any illegal or legal drug (including alcohol), which is capable of causing individual, social, or economic harm. The *host* is defined as a current, former, or potential consumer of alcohol and/or drugs. This may be an individual or a group. The *environment* represents the settings in which hosts and/or agents are found. *Environmental prevention* then is involved with the physical elements, territorial boundaries, legal definitions, and social, cultural, political and economic climate of a given setting and is built on methods and strategies which deal with ATOD-related problems within that defined setting.

Environmental prevention involves cooperative effort, developing and building support for solutions, formal adoption of plans, and follow-through to assure the change becomes a sustaining norm. Environmental prevention requires energy and follow-through to challenge the status quo which has benefitted from the conditions which are fostering ATOD problems. This may start with a civic organization, employer, or neighborhood group defining its own concerns about ATOD problems within an identifiable setting.

Environmental Prevention Examples

Approaches to alcohol problems:

- ending sales before dark at public events
- selling single cup only at public settings
- training for responsible beverage servers
- refusing alcohol sponsorship of community events
- publicizing the use of cellular phones to notify police of suspected DUIs in progress
- sponsoring sober graduation events
- reducing risks where social drinking occurs
- developing a policy of no use during the work day
- developing policies for no alcohol at employer-sponsored events
- training for servers at licensed alcohol outlets
- authorizing compliance checks of underage youth for illegal alcohol sales

Approaches to illegal drugs:

- watering parks in evening to preclude activity
- lighting requirements outside alcohol stores
- following through on small court claims for nuisance properties
- encouraging employer drug-free workplace policies
- encouraging employer drug testing
- making on-campus safe study rooms available after school
- training retailers on inhalant abuse items
- authorizing compliance checks of underage youth for illegal tobacco sales
- supporting "Take Back Our Streets" activities

For more information regarding Environmental Prevention, please call CMI at (800) 444-3066.❐

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February 1997

Fact Sheet:

California Friday Night Live and Club Live Program

The California Friday Night Live Program was established in 1984 to promote a teenage lifestyle free of alcohol and other drugs. The Friday Night Live (FNL) program prevents alcohol and drug use among teenagers through activities including community action, assemblies, and leadership training. The real work of Friday Night Live is done by teenagers. Chapter members participate in various community services such as adopting underprivileged families, serving in graffiti clean-up programs, and participating in the community process to influence policies regarding alcohol and other drugs. Just as important, Friday Night Live Chapters expose youth to the alternative of having a good time socially without the use of alcohol and other drugs.

Friday Night Live currently has certified Chapters in 419 high schools where 788,000 young people are served annually, making FNL one of the largest campus clubs in California. In addition, communities have started FNL chapters in youth recreation centers, juvenile detention facilities, and alcohol/drug recovery centers.

Club Live (CL) is a prevention program aimed at middle school students in California and is an extension of the successful FNL program. It assists students in developing alternatives to using alcohol, tobacco, and other drugs. The Club Live program currently includes 283 chapters throughout California serving over 150,000 students. The connection to the high school FNL program provides mentoring for Club Live students, and the high school students benefit from being valuable community participants.

Currently, 52 of California's 58 counties have Friday Night Live programs which are uniquely designed to meet their communities' needs. In addition, Club Live has been implemented in 48 counties in California since its inception six years ago.

In March 1996, the statewide coordination of the Friday Night Live and Club Live programs was shifted from the State Department of Alcohol and Drug Programs to the Tulare County Office of Education, a public entity. The contract with Tulare County is to administer the program statewide and to provide FNL/CL with greater innovation and private resources. Tulare County Office of Education is establishing a FNL Webpage that will make prevention information and FNL event information more easily accessible to individuals throughout California. The contractor is conducting a statewide survey of FNL/CL mentoring activities to assist them in developing a model mentoring program with an academic focus. Current FNL/CL mentoring activities vary by county. Some examples of FNL/CL mentoring activities include:

- FNL Kids Booster Club
- FNL Kids Red Ribbon Week presentations to K-6 classrooms
- FNL/CL Kids assist with anti-tobacco events for elementary kids
- CL Kids Elementary school students Tutoring Program
- FNL/CL Kids College-age students mentor FNL/CL Chapter Student Leaders
- FNL/CL Kids FNL/CL Chapter Student Leaders mentor students at Teencare FNL weekend camp.
- For more information regarding the Friday Night Live and Club Live Programs, please contact the Department of Alcohol and Drug Programs at (800) 444-3066, or the Tulare County Office of Education at (209) 733-6496. ❐

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February 1998

STATE OF CALIFORNIA
DEPARTMENT OF
ALCOHOL AND DRUG PROGRAMS

Fact Sheet:

Facts and Figures on Alcohol and Other Drugs

- Alcohol is a drug.
- Alcohol and other drug abuse is a major factor in chronic disease, the spread of infectious diseases, hospital emergency room visits, newborn health problems, violence and auto fatalities.
- An estimated 1.0 million adults in California are chronic drinkers (drinking 60 or more drinks per month).
- An estimated 2.9 million Californians aged 12 years or older used an illicit drug in the past year.
- Fetal alcohol syndrome, caused by drinking during pregnancy, is the NUMBER ONE cause of preventable mental retardation and birth defects in the United States.

Economic Impact*

- In California, the estimated cost of alcohol and other drug abuse to society is $19.8 billion. This estimate takes into consideration loss of productivity, health care costs, prevention and treatment costs, criminal justice costs and losses due to crime.
  - Drug abuse--about $8.0 billion annually;
  - Alcohol abuse--about $11.8 billion annually;

* Source: The Economic Cost of Alcohol and Drug Abuse and Mental Illness: 1985. U.S. Department of Health and Human Services.

Deaths

- Alcohol and other drug use kills approximately 6,200 Californians each year.
  - 3,487 Alcohol-related
  - 2,762 Drug-related

Traffic Accidents in California

- In 1996, there were 23,584 traffic collisions which involved alcohol:
  - 1,254 people died
  - 35,654 people were injured

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Arrests

- Approximately 38% of all arrests in California were drug/alcohol related. Over 606,000 Californians were arrested on drug- and alcohol-related charges in 1995:
  - 346,758 Alcohol-related
  - 260,018 Drug-related

Treatment Demographics

- Admissions for Drug Treatment

About 143,300 people a year are admitted to state treatment programs with a primary drug problem. "State treatment programs" refer to those programs receiving federal or state funds, or are licensed by the Department to operate a narcotic replacement treatment program.

The Primary Drug Used by Those Admitted

Heroin	52.7%
Cocaine/Crack	14.6 %
Amphetamines	20.6%
Marijuana/Hashish	9.1%
PCP	0.7%
Other	2.3%

Sex & Race/Ethnicity of Those Treated

	Drug Trmt Pgm	1990 CA Pop
Male	61.2%	50.1%
Female	38.8%	49.9%
White	48.4%	57.2%
Hispanic	28.2%	25.8%
Black	17.7%	7.0%
Asian/PI	2.1%	9.1%
American Ind	1.5%	0.6%
Other race	2.1%	0.2%

- Admissions for Alcohol Treatment

Each year, approximately 52,200 people enter state treatment programs with a primary alcohol problem. "State treatment programs" refer to those programs receiving federal or state alcohol funds. Private care facilities are not included in these statistics.

- Another 189,000 participate in Driving-Under-The-Influence Programs.

Sex and Race/Ethnicity of Those Treated

	Alcohol Trmt Programs	General Population	DUI Pgm Participants
Male	69.9%	50.1%	73.5%
Female	30.1%	49.7%	13.6%
White	55.2%	57.2%	42.1%
Hispanic	18.9%	25.8%	31.9%
African Amer	21.0%	7.0%	5.5%
Asian/PI	1.5%	9.1%	2.6%
Amer Ind	2.0%	0.6%	0.8%
Other	1.4%	0.2%	2.1%

March 1998

Fact Sheet:

Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS), a leading preventable cause of birth defects and mental retardation, results from consuming alcohol during pregnancy. FAS is a lifelong condition that is characterized by facial abnormalities, growth retardation, and central nervous system deficits including learning and developmental disorders. Not all children affected by prenatal alcohol use are born with the full syndrome, but may have selected abnormalities.

It is now widely accepted that alcohol effects are specifically related to dose (how much alcohol is consumed) and gestational time. Research shows that alcohol affects fetal cell development in different ways, which results in a broad spectrum of outcomes based on the dose and timing of fetal development. The most consistent predictors of negative effects from prenatal exposure to alcohol consumption are binge drinking (five or more drinks on one occasion) and drinking prior to recognition of pregnancy. The first trimester of pregnancy is the most critical gestational period for susceptibility to alcohol-related negative birth outcomes; however, it is clear that there is no safe prenatal period of alcohol exposure or safe consumption level.

Estimates of the prevalence of FAS vary from 0.2 to 1.0 per 1,000 live births.[1] When these prevalence rates are applied to the number of live births in California, it is estimated that there are approximately 120 to 600 babies born with FAS in California each year. In addition to cases of full FAS syndrome, there are 1,800 to 3,000 additional children born each year in California who will exhibit less severe effects termed fetal alcohol effects (FAE) or alcohol related birth defects (ARBD).[2] Based on a 1992 California study, the prevalence rate for alcohol use among pregnant women at delivery is estimated at 6.72%[3], which means that as many as 40,000 children born in California are prenatally exposed to alcohol each year.

Health advisories urging women, either pregnant or planning a pregnancy, not to drink alcohol were first issued by the U.S. Surgeon General in 1981 and were reiterated by the Secretary of Health and Human Services in 1990 and 1995. In 1997, the importance of getting the alcohol abstinence message out was re-emphasized after the results from a survey by the Centers for Disease Control and Prevention (CDC) were released. The survey found that rates of frequent drinking (more than seven drinks per week or more than five drinks on any occasion in the past month) among pregnant women have increased substantially from .8% in 1991 to 3.5% in 1995. The rate of 3.5% in 1995 translates to at least 140,000 pregnant women in the U.S. each year drinking at levels that pose a risk for FAS.

The CDC report recommends that health care professionals inform their patients who are pregnant or are planning to become pregnant that there is no safe limit of alcohol to be consumed during pregnancy, and national organizations are working with medical schools to ensure that curriculum includes education on the dangers of such use.

For more information regarding FAS, please call the Program Operations Division (POD) at (916) 323-4445. ❐

1 Centers for Disease Control and Prevention, Fetal Alcohol Syndrome Fact Sheet, April 25, 1997.

2 Based on Abel and Sokel's 1987 study estimate that 3 to 5 children per 1,000 births will have ARBD.

3 Noble, A. (1995). ''Prenatal Substance Abuse in California: Findings from the Perinatal Substance Exposure Study.'' Report for the California Department of Alcohol and Drug Programs, Sacramento, CA.

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March 1998

Fact Sheet:

Fiscal Operations

Within the Program Operations Division, the Fiscal Management Branch (FMB) supports the Department by accounting for and reporting on the funds that counties and providers claim for Drug/Medi-Cal (D/MC) and Negotiated Net Amount (NNA) contract services. Specifically, the FMB:

- processes and reconciles D/MC claims and reports, processes and approves interim payment claims, and processes claims for individual beneficiary claims from *Sobky v. Smoley*, minor consent, CalWORKs, and EPSDT services;
- maintains a D/MC Payor's List and Master Provider File allowing D/MC reimbursements to be made to specific providers and other publicly funded treatment programs to be identified in the State's service delivery system;
- reconciles year-end cost reports for county NNA contracts, county combined NNA and D/MC contracts, and direct provider D/MC contracts; and
- computes and sets annual reimbursement rates.

There are two sections in the FMB - the Fiscal Systems Section and the Drug/Medi-Cal Claims Section.

Fiscal Systems Section

Counties and direct contract providers are required to submit an annual year-end cost report which identifies actual expenditures of funds allocated by the Department. For the fiscal year ending on June 30, cost reports are due to the Department by November 1 of that same calendar year. Staff in the Fiscal Systems Section (FSS) process and reconcile those annual year-end cost reports. In doing so, instructions for completing cost reports are written and distributed; training and technical assistance are provided; problems are researched and resolved; and recommendations for preliminary and interim settlements and payments are made. The preliminary settlement is the settlement of actual allowable costs or expenditures as reported in the year-end cost report for Alcohol and other Drug services and Perinatal services, excluding

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Drug/Medi-Cal services and the interim settlement is the settlement of actual allowable costs or expenditures as reported in the year-end cost report for Alcohol and other Drug services and Perinatal services, including Drug/Medi-Cal services, if applicable. Sixty-seven (67) cost reports (D/MC direct contract providers and county NNA and D/MC contracts) were processed for Fiscal Year (FY) 1995-96. However, depending on the number of direct contract providers, the total number of cost reports processed may change each year.

Drug/Medi-Cal Claims Section

The D/MC claim process provides the payment mechanism for federal and state funds dedicated to the D/MC Program. When certified D/MC providers provide D/MC services to eligible Medi-Cal beneficiaries, those services may be billed for and reimbursed to the provider. Staff in the D/MC Claims Section review and process paper hard copy, magnetic tape, and/or diskette claims from counties and providers; review, process, and reconcile the resulting approved, error correction, suspended, and other reports resulting from the initial claims; provide technical assistance to counties and providers in submitting their claims; and process disallowances for services not in compliance with D/MC requirements. Statewide processes such as rates development and automated claiming are also managed by this section.

D/MC claims are tracked by specific treatment modalities, individual provider, units of service (UOS) billed and approved for payment, and regular or perinatal program services. For FY 1996-97, 3.95 million UOS for regular D/MC services were billed by providers and processed; 3.64 million UOS were approved and $47.69 million was paid for the approved services. For perinatal D/MC services, 73,028 UOS were billed and processed; and $4.4 million was paid for the 64,305 UOS approved.

To facilitate cash flow for the provision of alcohol and other drug treatment services to Medi-Cal beneficiaries, counties and providers may request and subsequently receive interim payments of State General Funds (SGF) for D/MC services based on approved contract amounts. The D/MC Claims Section coordinates the processing of interim payments and ensures a sufficient balance of funds are available in the contractor's agreement before payments are approved for release. In FY 1996-97, interim payment requests for $23.5 million in SGF were processed. ❐

October 1996

Fact Sheet:

Gang Violence Suppression Program
Suppression of Drug Abuse in Schools Program

The Gang Violence Suppression Program and the Suppression of Drug Abuse in Schools Program are funded and monitored by this department and managed under an Interagency Agreement with the Office of Criminal Justice Planning (OCJP). Funding for both programs is made available by the Safe and Drug Free Schools Act of 1994. By law, these programs receive 20% of the Governor's Discretionary portion of this annual federal grant to California. Total funding for both programs in FY 1996-97 is $2,279,663.

In the 1996-97 Fiscal Year the **Gang Violence Suppression Program** consists of five subcontracts (of approximately $100,000 each) to local community agencies. These agencies will provide services in two or more of the following categories: conflict resolution services, mentoring programs, individual/family counseling, vocational training and job placement.

The agencies receiving funding are:

- Bay Asian Youth Center
- Community Couseling Service (Los Angeles)
- Project IMPACT- Delano
- The Boys and Girls Club of Westminister
- Young Horizons (Long Beach)

The **Suppression of Drug Abuse in Schools Program**, in the 1996-97 Fiscal Year, includes 17 projects subcontracted to local agencies to create partnerships between law enforcement agencies and school districts. These projects place uniformed police or sheriff's department personnel on school campuses to involve and train students, parents, teachers and school administrators in suppression of drug abuse and related gang activities.

The agencies receiving funding in the 96-97 FY are:

- Anaheim Union School District
- East Bay Asian Youth Center
- El Monte City School District
- Humboldt County Office of Education
- Laton Unified School District
- Lompoc City School District
- Merced County Office of Education
- Palo Verde Unified School District
- Redlands Unified School District
- Sanger Unified School District
- Santa Cruz County Office of Education
- Santa Rosa Police Department
- Temecula Valley Unified School District
- Tulare City School District
- Turlock School District
- Vallejo City Unified School District
- Washington Unified School District

Responsibility for Safe and Drug Free Schools Block Grant policy issues, administration, and monitoring of the OCJP Interagency Agreement are the responsibility of the Contracts Management Branch of the Division of Children, Youth, Families and Communities. ❐

For further information contact:

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Special Projects Section
Contracts Management Branch
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GPC
State of California

Governor's Policy Council on Drug and Alcohol Abuse

Introduction

California's large and diverse population has made this state one of the largest alcohol and drug-consuming states in the nation. It is estimated that in the State of California alone, the cost to society is more than $14 billion a year due to the problems associated with alcohol and other drugs. This fact, coupled with California's large geographical area, has encouraged the development of numerous intrastate drug trafficking organizations which exist primarily to exploit the California market. In recent years, however, this activity has expanded to meet a national market demand.

The Governor's Policy Council on Drug and Alcohol Abuse (GPC) was established to develop a unified and integrated strategy aimed at combatting the complicated array of problems posed by alcohol and other drugs. Each year, the GPC prepares and submits to the Governor an integrated plan for alcohol and drug abuse enforcement, treatment, and prevention programs and services. The GPC also ensures the effective implementation of these programs, along with the cost-effective expenditure of state and federal funds. The GPC carries out its responsibilities through its headquarters located within the Department of Alcohol and Drug Programs in Sacramento.

History

Recognizing the need for a comprehensive and coordinated framework to ensure the success of California's drug control strategy, the Governor's Policy Council on Drug and Alcohol Abuse (GPC) was established in February of 1988, by Executive Order.

In January, 1991, Governor Pete Wilson appointed Andrew M. Mecca, Dr.P.H. as Director of California's Department of Alcohol and Drug Programs, and Chairman of the GPC.

Dr. Mecca is responsible for coordinating statewide activities to ensure that California 's programs and policies for addressing alcohol and other drugs are nonduplicative, well-planned, and coordinated.

The GPC draws on the expertise of 17 different state entities to coordinate California's drug control activities. Specifically, the secretaries and directors of the following state departments and offices form and constitute the Governor's Policy Council on Drug and Alcohol Abuse:

- Department of Justice
- Department of Education
- Health & Welfare Agency
- Office of Child Development & Education
- Department of Alcohol and Drug Programs
- Department of Corrections
- Department of Health Services
- California National Guard
- Department of Mental Health
- Office of Traffic Safety
- Department of Youth Authority
- Department of Alcoholic Beverage Control
- Department of Commerce
- Department of California Highway Patrol
- Office of Criminal Justice Planning
- Department of Aging
- Department of Social Services

State of California
Governor Pete Wilson

Governor's Policy Council on Drug and Alcohol Abuse
Andrew M. Mecca, Dr.P.H.
Chairman

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Contact: Salle Jantz,
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Office of Legislative Affairs
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Governor's Policy Council on Drug and Alcohol Abuse

Department of Justice
Honorable Daniel E. Lungren
Attorney-General

Department of Education
Delaine Eastin
Superintendent of
Public Instruction

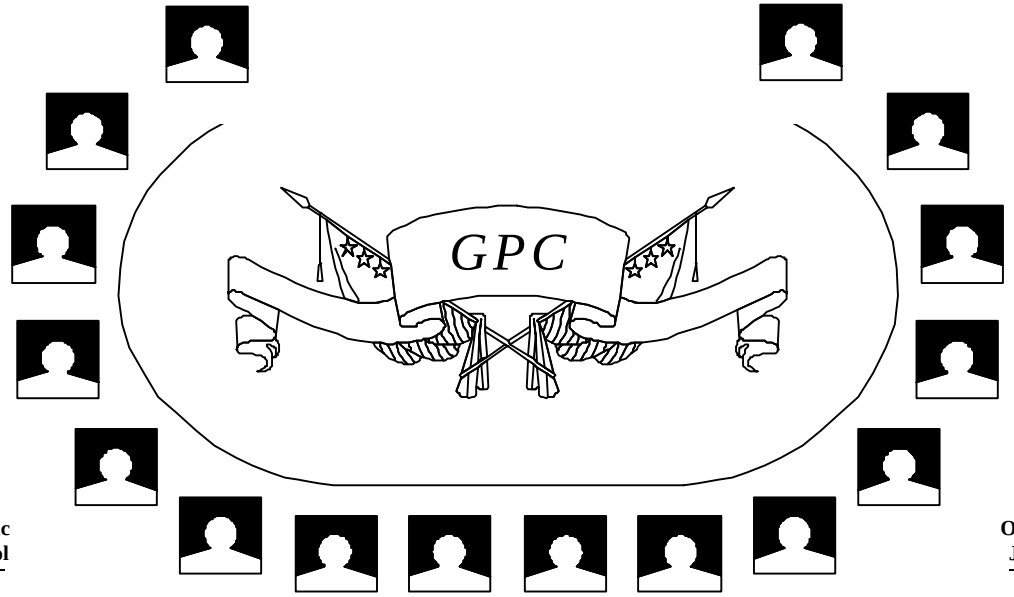
Chairman
Andrew M. Mecca, Dr.P.H.
Director
Department of Alcohol
and Drug Programs

Judicial Branch
Honorable Patrick Morris
Superior Court

Department of Community Services & Development
Michael J. Micciche
Director

Child Development & Education
Marian Bergeson
Agency Secretary

Health & Welfare Agency
Sandra R. Smoley, R.N.
Agency Secretary



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California National Guard
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Tandy K. Bozeman

Department of California Highway Patrol
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Department of Youth Authority
Francisco J. Alarcon
Director

Dept. of Alcoholic Beverage Control
Jay Stroh
Director

Office of Criminal Justice Planning
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Dept. of Aging
Dixon Arnett
Director

Trade & Commerce Agency
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Dept. of Mental Health
Stephen W.
Mayberg, Ph.D.
Director

Office of Traffic Safety
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Director

Dept. of Social Services
Eloise
Anderson
Director

98041

April 1997

Fact Sheet:

Latina Assessment & Outreach Campaign

Overview

The Department of Alcohol and Drug Programs (ADP) completed a study entitled the ''Perinatal Substance Exposure Study'' (PSES) to determine the number of births affected by alcohol and other drugs (AOD) in California. The 1992 study indicated:

- 11.35 percent of babies were born to mothers who had used alcohol and/or other drugs just prior to delivering. This is about one in nine babies born.
- Of mothers who used alcohol or drugs prior to giving birth approximately 36.6 percent, were Latina women.
- Latina women in the study also had the highest rate of alcohol only use prior to delivery, 45.1 percent of the 41,000 alcohol exposed births.
- Approximately 17.2 percent of the women currently being served by perinatal substance abuse treatment programs are Latina.

This indicates that pregnant and parenting Latina women are not being adequately served in perinatal substance abuse treatment programs.

Outcome

This data supports the need for innovative, culturally specific outreach, education, and prevention programs to inform pregnant and parenting Latina women about the dangers of alcohol and drug use during pregnancy, and the availability of alcohol and drug treatment services.

Through a contract with the California Hispanic Commission on Alcohol and Drug Abuse, Inc. ADP is now in the process of producing a strategic plan for providing more effective alcohol and drug programs and developing culturally competent outreach and educational materials on the dangers of alcohol and drug use during pregnancy especially for Latinas. The plan also includes recommendations for addressing the barriers to availability and accessibility to substance abuse treatment services for Latinas. ❐

For more information regarding the Latina Assessment and Outreach Campaign, please call the Office of Perinatal Substance Abuse at (916) 323-4445.

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November 1997

Fact Sheet:

Licensing & Certification of Alcoholism or Drug Abuse Recovery or Treatment Programs

ADP's Licensing and Certification Branch (L&C) licenses California's alcoholism and drug abuse recovery or treatment facilities providing 24-hour residential nonmedical services to adults. The authority to license alcohol facilities was transferred to ADP from Department of Social Services in 1985. Authority for licensing drug facilities was transferred in January of 1990. (Methadone programs and driving-under-the-influence programs are licensed by two other branches of ADP.) On a voluntary basis, the L&C Branch also certifies alcohol and drug programs which meet or exceed state program standards.

LICENSING

Residential facilities that provide nonmedical alcoholism or drug abuse recovery, treatment, or detoxification services to adults must be licensed by the Department of Alcohol and Drug Programs (ADP). Nonresidential programs are not required to be licensed. Health and safety concerns are the primary focus of the licensing process (e.g., fire clearance, food service, personnel requirements, physical environment, and personal rights.)

Local officials may require use permits, depending on the type of residential facility involved. Licensed residential facilities serving six or fewer residents are exempt from local government regulations.

As of September 1997, there are over 600 facilities operating under license from ADP. Applications for new facilities are received at an average rate of 8 per month.

CERTIFICATION OF RESIDENTIAL PROGRAMS

Certification is voluntary for all programs. It is considered advantageous in gaining the confidence of both potential residents and third party payers, as it signifies a program which both meets minimal levels of service quality and is in substantial compliance with state program standards. Participating programs also benefit through the associated technical assistance, training and suggestions for program improvements which are available within the state's alcohol and drug program network. Approximately 68% of the licensed residential facilities are alcohol and/or drug certified. The Licensing and Certification Branch also certifies residential facilities that are licensed by the Department of Social Services - Community Care Licensing Branch, the Department of Health Services, as well as facilities operated by the Department of Corrections.

CERTIFICATION OF NONRESIDENTIAL PROGRAMS

There are currently over 260 nonresidential (nonresidential programs do not require licensure) programs that have been granted certification.

There are an undetermined number of nonresidential drug or alcohol programs operating in the state. ADP identifies only those nonresidential programs which request certification. ❐

☐ COMPLAINTS

ADP investigates all complaints. The Department averages over 15 complaints per month. Unannounced site visits are normally scheduled as a routine practice of complaint investigation, or to determine facility compliance with deficiencies identified through the normal site visit process.

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Licensing of Alcoholism or Drug Abuse Recovery or Treatment Facilities:

The Most Frequently Asked Questions

What is the process for licensing a facility?

Prospective residential facilities that plan to provide nonmedical alcoholism or drug abuse recovery, treatment, or detoxification services to adults need to contact the Department of Alcohol and Drug Programs (ADP) - Licensing and Certification Branch at (916) 322-2911 to request a license application. Prior to initial licensure, the applicant must complete a written application, submit an approved fire clearance from the local fire authority, pay all applicable license fees (nonprofit entities are exempt from paying licensing fees), and pass a facility site inspection by the Department of Alcohol and Drug Programs to determine compliance with all applicable laws and regulations. When the facility has been found to be in compliance ADP will then issue a license valid for two years.

What constitutes a ''program'' for purposes of determining the need for a license?

Section 10501(a)(6)[1] of Title 9, California Code of Regulations (CCR), defines a program as providing one or more of the following services within a residential setting:

- detoxification
- educational counseling
- individual or group counseling sessions
- treatment or recovery planning.

What program areas are addressed by licensure?

The licensing application process includes a thorough review of the facility's program in the following areas: fire clearance, water supply clearance, plan of operation [including compliance with the Americans' with Disabilities Act], capacity determination, reporting requirements, personnel requirements, personnel records, admission agreements, health screening, resident records, personal rights, telephones, transportation, health-related services, food service, activities, building and grounds, outdoor and indoor activity space, storage space, and fixtures, furniture, equipment, and supplies.

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1 Section 10501(a)(6) - ''Alcoholism or Drug Abuse Recovery or Treatment Service'' means a service which is designed to promote treatment and maintain recovery from alcohol or drug problems which includes one or more of the following: detoxification, group sessions, individual sessions, educational sessions, and recovery or treatment planning." [Under the general provisions of Section 10500, the preceding definition specifically describes services which are provided within ''facilities'' licensed under Chapter 7.5 of Part 2 of Division 10.5 of the Health and Safety Code. As defined in Section 10501, ''facilities'' provide residential-based services.]

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What facilities do not require licensure by ADP?

Facilities which provide a cooperative living arrangement (sometimes referred to as a sober living environment or alcohol and drug free housing) for persons recovering from alcoholism or alcohol and/or drug abuse in which the residents govern themselves, and which do not provide any of the services specified above, do not require licensure. In addition, facilities which use primarily religious practices to recover from alcoholism or drug abuse ***may not*** require licensure (determination will be made by the Department after reviewing written application and supportive documentation). Also, facilities with licenses or approval from other departments (Department of Social Services, Department of Health Services, Chemical Dependency Hospitals, and Community Correctional Centers {facilities housing prisoners under Section 6250 of the Penal Code}) are not required to obtain additional licensure from ADP.

It is important to note while sober living environments or alcohol or drug free housing are not required to be licensed by ADP, they may require business permits or clearances from the local city or county in which the houses are located.

What role do local governments play in the licensing process?

ADP is the sole licensing authority for residential nonmedical alcoholism or drug abuse recovery or treatment facilities. Local officials are involved in zoning of property for commercial or residential use and issuance of use permits and business licenses.

Facilities providing services to six or fewer people are exempt from local ordinances (not exempt from ADP licensure) and other restrictions, under State Health & Safety Code Section 11834.23[2]. Under Section 11834.23, the smaller facility (six or fewer residents) operator can be treated no differently than would a family occupying a single-family home.

Local fire safety inspectors (or a representative from the State Fire Marshal's Office) conduct site visits in every facility applying for licensure to determine compliance with fire safety regulations. Although ADP may issue a license without regard to a conditional use permit, no license can be issued without an appropriate fire safety clearance. Facilities utilizing central food service may also be subject to special permits issued through the local health department.

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2 Section 11834.23—"Whether or not unrelated persons are living together, an alcoholism or drug abuse recovery or treatment facility which serves six or fewer persons shall be considered a residential use of property for the purposes of this article. In addition, the residents and operators of such a facility shall be considered a family for the purposes of any law or zoning ordinances which relates to the residential use of property pursuant to this article.... No conditional use permit, zoning variance, or other zoning clearance shall be required of an alcoholism or drug abuse recovery or treatment facility which serves six or fewer persons that is not required of a single-family residence in the same zone..."

What laws govern the licensing and location of these facilities?

Section 11834.01 of the California Health and Safety Code governs the licensing of the facilities. Locations are governed by local zoning and business ordinances. The Federal Fair Housing Act of 1988 provides protection from discrimination for facilities serving persons recovering from problems related to the use of alcohol or other drugs. The Uniform Building Code identifies the fire clearance requirements.

Who do these facilities serve?

Residential facilities licensed by ADP serve adults (18 & older) addicted to alcohol or other drugs who wish to recover. Adult facilities may serve a very limited number of adolescents (14-18) on a waiver basis. Dependent children may also reside in some facilities with their parents.

What types of services do these programs provide?

Facilities licensed by ADP provide education/group/individual sessions, recovery or treatment planning, and detoxification services. Additionally, the facility may also provide peer support, social and recreational activities, and information about and referral to appropriate community services.

How are these services paid for?

Payments for services are arranged by agreement between the resident and the facility. Some facilities receive federal and state funds, through contracts with counties. County contracted facilities usually can offer lower rates, but residents are expected to pay based on their financial ability, except that these facilities cannot refuse services to an individual based solely upon the individual's inability to pay. Although costs may vary, any recovery or treatment service fee must be addressed in a written agreement at time of admission.

How does the State investigate situations involving unlicensed facilities?

If ADP receives a complaint which a facility is alleged to be in violation of operating without a license, ADP staff shall initiate an investigation within ten working days of receipt of the complaint. If ADP finds that services are being provided unlawfully, ADP will notify the operator to cease operation. ADP does have the authority to assess fines for noncompliance if unlicensed facilities fail to comply, and may ask a court assistance to order closure of a facility. ❐

October 1995

Fact Sheet:

NARCOTIC TREATMENT PROGRAM LICENSING BRANCH LAAM

The use of medications in the treatment of narcotic addiction has been shown to be an effective replacement narcotic therapy of selected narcotic addicts. Recent legislation has increased California's choice of medications to include a new opioid medication called LAAM.

What is LAAM?

LAAM (levo - alpha - acetylmethadol) is a narcotic medication. It is used as one component of a comprehensive treatment program for narcotic addiction, along with a medical evaluation, treatment planning, and counseling.

When did it become available to California?

The signing of AB 1113 (Rogan), on September 5, 1995, makes LAAM available in California. The new medication authorized by Chapter 455, 1995 Statutes, adds a new maintenance alternative for the treatment of narcotic addiction.

How does LAAM work?

LAAM works similar to morphine and affects the central nervous system. It has two important qualities: 1) It suppresses opiate withdrawal symptoms up to 72 hours and blocks the ''high'' often associated with illicit opiate use, and 2) its onset of action is slow after oral administration which makes it an undesirable drug for abuse.

What are the advantages of LAAM?

- LAAM is taken orally rather than injected. This reduces opportunity for HIV infection and hepatitis, which are known to be transmitted by injection drug use and needle sharing. No take-home doses are permitted, which reduces the possibility of diversion.
- The longer effect of LAAM provides narcotic treatment programs with more flexibility in treating narcotic addiction.

Who can take LAAM?

Anyone participating in, or is a patient of, a licensed narcotic treatment program and if the program's physician and treatment team decides it is appropriate replacement narcotic therapy.

Where can I get more information?

The Narcotic Treatment Program Licensing Branch of the Department of Alcohol and Drug Programs licenses narcotic treatment programs and oversees the delivery of services to patients. For information on LAAM, please contact the Department of Alcohol and Drug Programs, Narcotic Treatment Program Licensing Branch, using the address or phone numbers at the bottom of this page. ❐

Quality Assurance Division
Narcotic Treatment Program Licensing Branch
CA Dept. of Alcohol and Drug Programs
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FAX: (916) 323-0659; TDD: (916) 445-1942

September 1995

Fact Sheet:

NARCOTIC TREATMENT PROGRAM LICENSING BRANCH METHADONE

Residing in California are over 125,000 people addicted to the intravenous use of heroin. Under law, persons addicted to heroin or other opiates or opiate-like drugs may qualify for treatment with methadone, a synthetic narcotic, often as a treatment of last resort. Like any narcotic, methadone produces physical dependence, but it is longer acting than heroin and is taken orally rather than injected, rendering the use of needles unnecessary to the patient/addict's recovery.

EFFECTIVENESS OF METHADONE MAINTENANCE

Methadone is a synthetic narcotic used in drug replacement therapy, which appears to normalize brain chemistry and permit resumption of a normal life. One dose per day is all that is needed to relieve craving and prevent withdrawal symptoms. In addition, once a patient's dosage is stabilized, methadone no longer provides a ''high''. Patients tend to lead relatively normal and productive lives. Providing or subsidizing methadone maintenance results in a net savings to society. Further, because methadone is taken orally, the risk of transmitting disease through sharing of contaminated needles is eliminated.

Compared to other forms of treatment for narcotic addiction, methadone maintenance is considered to be highly effective and relatively low cost. Methadone maintenance has been shown to decrease illicit drug use, assist in preventing the transmission of the AIDS virus among drug users, save lives of newborn children born to narcotic-addicted mothers, increase employment, and decrease criminality.

NARCOTIC TREATMENT PROGRAM LICENSING BRANCH

The Narcotic Treatment Program Licensing Branch (NTPLB) of the Department of Alcohol and Drug Programs (ADP) licenses methadone maintenance and detoxification programs and oversees the delivery of methadone treatment services to patient/addicts.

The NTPLB evaluates applications for new methadone program licenses, requests for program size increases for existing licensees, and performs annual on-site inspections for approximately 231 licensed programs at 104 locations. California's methadone programs have the aggregate capacity to treat over 28,000 people a day with methadone. The majority of this treatment capability is used for methadone maintenance (approximately 22,000 people), with the remainder (6,000) undergoing 21-day methadone detoxification.

Evaluations and inspections are conducted to ascertain the licensees' compliance with the State Methadone Regulations and with federal law and regulations. Licensees which do not comply are subject to a process of progressive discipline, ranging from admonitions and written corrective action plans to temporary suspension or permanent revocation of the license.

PUBLIC HEALTH INITIATIVE

In 1986 ADP obtained authority to approve temporary program expansions and waivers of standard admission criteria to assist communities in dealing with public health crises, particularly the burgeoning threat of AIDS virus transmission through contaminated needle use. Subsequent ''emergency'' regulations allowed methadone programs to quickly admit to treatment many patient/addicts who otherwise may have only been treated after long delay, if at all.

As of early 1991 this public health-related initiative allowed the daily treatment of an additional 3,000 patient/addicts with methadone, 2,700 on maintenance and the remainder undergoing detoxification.

Continued Growth Is Expected

The size of California's methadone treatment capacity is increasing each year. This is attributed to the increased availability of public funding aimed at reducing waiting periods experienced by patient/addicts seeking methadone services. Methadone service capability increased by 46% in California between 1986 and 1991.

FUNDING

The majority of methadone maintenance in California is paid by patients out-of-pocket. Subsidized treatment comes from a variety of government sources, including State general funds, federal block grants, Drug Medi-Cal funds, and local government funds. Some special federal grants are available to counties for specific programs, such as treatment for individuals infected with the AIDS virus. The majority of government subsidization pays for treatment of adults of limited incomes in not-for-profit clinics. ❐

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Methadone Maintenance:

The Most Frequently Asked Questions

What is methadone?

Methadone is a narcotic which is efficiently absorbed when taken by mouth.

Is methadone addictive?

Like several other useful drugs, methadone produces physical dependence. However, we now use the term ''addiction'' to refer to behavior which is compulsive, out of control, and persists in spite of adverse consequences. If someone on methadone is not using illicit drugs, and using legal ones as prescribed, methadone can be viewed as simply another medication.

What is methadone used for?

1. Relief of pain in general medical practice.
2. Treatment of narcotic addiction.

Does methadone have side effects?

Methadone does cause physical dependence. It has no known serious or prolonged side effects, even when taken daily for several years.

Why is methadone helpful in treatment of narcotic addiction?

It is longer acting than heroin and other street abused narcotics. The effects of methadone last 24-48 hours compared to heroin's 4-6 hours.

Methadone is effectively administered by mouth. None of the problems common with intravenous drug abuse are present with oral administration of methadone.

Because it is long acting, methadone is generally administered once daily. Consequently, rather than cycling from craving, to a high or euphoric state, to nodding, to restlessness and back to craving every few hours, methadone patients have a more stabilized life. This stability permits patients to work full time, attend full time educational programs and be a responsible parent and homemaker without the disruptive effects of heroin and other street narcotic drugs.

How effective is methadone treatment?

Methadone maintenance patients dramatically reduce illicit drug use and over time most patients eliminate illicit drug use while they are in treatment.

More than 50 percent of maintenance patients in treatment six months or more are employed full time, are full time students, or are responsible homemakers. The need for illegal activities to support illicit drug use is eliminated.

In summary, methadone is a very effective treatment tool that, over time, substantially reduces or eliminates those problems directly linked to illicit street narcotic use.

What is the size of the methadone treatment system in California?

- Number of methadone treatment sites.....104
- Number of counties with sites.....27
- Number of maintenance slots.....22,000
- Number of detoxification slots.....6,000
- Total number of methadone slots.....28,000

How are methadone treatment services funded?

Most methadone treatment in California is paid for by patient fees. In addition, federal, state and local funds go to programs through county contracts to assist with payment for services to pregnant patients and others who are unable to pay. Funding resources also include Medi-Cal, and third party payers such as insurance companies.

Who runs methadone programs?

About 90 percent of California methadone programs are privately owned and operated. The remainder are mostly owned and operated by city or county governments. Treatment aspects of each program are under the supervision of a medical director who is a licensed medical doctor. Overall program operation is the responsibility of a designated program director. ❐

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women and children attending perinatal programs:

- Successful treatment outcomes increased with the length of time in treatment.
- Therapeutic services for children resulted in fewer school drop outs, less truancy, and reduced juvenile delinquency.
- Involvement with child welfare decreased.
- Child/mother reunifications increased.
- Length of time children spent in foster placement decreased.

In progress are the ***Perinatal Services Network (PSN) Evaluation*** **and the** ***Perinatal American Indian Study*** (PAIS). The PSN Evaluation is a two year research project to assess the services provided by the PSN. The PAIS will identify the specific substance use patterns and service needs of American Indian women in urban and rural areas of California.

3. Educate Service Providers on Effective Strategies

The Children, Youth, Families & Communities (CYFC) Division provides, or arranges for, technical assistance and training to alcohol and drug treatment providers that includes workshops and training events, one-on-one consultations, and manuals and other written materials.

Training also is available to other professionals and public and private agencies that work with the perinatal population, such as physicians, judges, maternal child health consultants, adolescent program counselors, school districts, and county health and human services agencies.

4. Coordination and Collaboration

CYFC works closely with other State departments and constituency groups to share information and resources and avoid duplication of responsibilities. Collaborative projects focus on the following subjects:

- children's issues
- domestic violence
- education
- criminal justice
- family preservation and support
- ethnic and cultural diversity
- integrated school-linked services
- women's health and mental health issues

5. Inform the Public About the Dangers of Alcohol and Drug Use During Pregnancy

CYFC develops and makes available education, outreach, and other materials, such as research findings. To obtain a complete list, please contact the Resource Center of the California Department of Alcohol and Drug Programs at (800) 879-2772. ❐

March 1998

Fact Sheet:

Negotiated Net Amount (NNA)

Overview

Trailer Bill 627, Chapter 64, Statutes of 1993: (1) opened the Negotiated Net Amount (NNA) Pilot Project to all counties for Fiscal Year 1993/94; (2) terminated the pilot project on June 30, 1994; and (3) required the Department of Alcohol and Drug Programs (ADP) to negotiate, on or before July 1, 1994, multi-year contracts with every county thereafter.

History

Formerly, the counties were required to submit county plans to ADP. The process required that the county plans for both the alcohol program and the drug program be submitted annually and did not allow for the transfer of unspent State General Funds to the following fiscal year.

Negotiated Net Amount (NNA) Contract

NNA contracts are negotiated for a combined alcohol and drug program allocation. ADP and the county negotiate and agree upon a fixed amount of funds for services based upon dedicated capacity for providing alcohol and drug services to persons eligible for county services.

''Dedicated capacity'' is the ability of the county to insure the availability of staff, facilities, and other resources necessary to provide alcohol and drug services. Dedicated capacity is expressed in ''units of service'' such as:

- Driving Under the Influence;
- clients served;
- support services,
- available staff hours;
- inpatient methadone detoxification,
- available bed days; etc.

NNA contracts were initially negotiated for three fiscal years (i.e., July 1, 1994 through June 30, 1997). Negotiations for the subsequent years were conducted by correspondence. The original three year NNA contract was amended for a fourth year through June 30, 1998. This was to insure that ADP and the counties complied with provisions of AB 2071.

The county is reimbursed monthly in arrears.

Unspent State General Funds identified by April 1 may be retained by the county (exclusive of funding from the Department of Corrections) and spent on identifiable alcohol and drug service priorities, provided that the county demonstrates the negotiated dedicated capacity was met. The county and ADP agree upon an expenditure plan for the unspent funds in the next fiscal year.

Unspent Federal Funds identified by April 1 may be redirected to the next fiscal year subject to approval of the State Legislature, and an amendment to the current fiscal year contract.

Counties participating in the NNA Contract process must submit financial reports and various other reports including: treatment and prevention services reports, demographic characteristics of service recipients, utilization reports, compliance reports, and end-of-year cost data.

Counties may submit an amendment to the NNA contract at any time. The respective county and ADP will reach agreement on the amendment provisions as in the original contract process. ❐

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March 1998

Fact Sheet:

Perinatal Programs: Alcohol & Drug Services

The Office of Perinatal Substance Abuse (OPSA) oversees a statewide network of approximately 249 publicly-funded perinatal alcohol and drug treatment programs that annually serve over 12,000 pregnant and parenting women accompanied by approximately 18,400 children (from birth through age 17). Programs may supplement their budgets with grants and contributions and can charge fees based on a client's ability to pay. In addition, State and federal perinatal funds support activities in research, technical assistance, collaboration and coordination, and education and outreach.

Perinatal Alcohol and Drug Services

- ❒ Programs empower women to achieve and maintain clean and sober living, deliver healthy infants, strengthen family units, and lead productive lives.
- ❒ Services are designed to be gender specific and culturally relevant.
- ❒ The Perinatal Services Network includes a continuum of care through the following treatment modalities:
  - Outpatient Drug-Free,
  - Daycare Habilitative,
  - Residential,
  - Outpatient Methadone Maintenance,
  - Transitional Living Centers, and
  - Alcohol and Drug-Free Housing.
- ❒ Services are based on county needs and demographics.
- ❒ Program components include:
  - a core alcohol and drug treatment program;
  - women specific issues;
  - comprehensive case management;
  - cooperative child care;
  - transportation;
  - parenting skills building;
  - health education;
  - child development education; and
  - linkages to medical, HIV / TB testing and counseling, education, vocational, and other services.

Program Results

- ❒ Approximately 71% of babies born to women in perinatal treatment programs test negative for alcohol or other drug exposure. These kinds of results are essential to ending the inter-generational cycle of abuse and addiction.
- ❒ For women and children attending perinatal programs:
  - successful treatment outcomes increased with the length of time in treatment;
  - therapeutic services for children resulted in fewer school drop outs, less truancy, and reduced juvenile delinquency;
  - child/mother reunifications increased; and
  - involvement with Child Welfare and length of time children spent in foster placement decreased.

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July 1997

Fact Sheet:

Perinatal Services: Mission & Goals

ENABLING LEGISLATION

AB 3010 Speier, 1990

MISSION

To empower substance abusing women to achieve and maintain clean and sober living, deliver healthy infants, strengthen family units, and establish productive lives.

GOALS

1. Implement a Statewide Network of Comprehensive Treatment Services

- Over 200 perinatal alcohol and drug treatment programs serve approximately 9,000 women accompanied by 13,500 children (birth through age 17) annually.
- Programs are designed to be gender specific and culturally relevant.
- Services are based on county needs and demographics.
- Program components include:
  - ✓ a core alcohol and drug treatment program;
  - ✓ women specific issues;
  - ✓ comprehensive case management;
  - ✓ cooperative child care;
  - ✓ transportation;
  - ✓ parenting skills building;
  - ✓ health education;
  - ✓ child development education; and
  - ✓ linkages to medical, HIV/TB testing and counseling, education, vocational, and other services.

2. Support Research to Identify Service Needs

The 1992 ***Perinatal Substance Exposure Study*** (PSES) obtained accurate population-based estimates of the number of substance-exposed infants (69,000) born in California and the demographic profiles of their mothers. Findings are

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being used in State and local targeted outreach and treatment planning efforts.

The three year ***Options for Recovery Pilot Project Evaluation*** was completed in June 1994. Major findings include that for women and children attending perinatal programs:

- Successful treatment outcomes increased with the length of time in treatment.
- Therapeutic services for children resulted in fewer school drop outs, less truancy, and reduced juvenile delinquency.
- Involvement with child welfare decreased.
- Child/mother reunifications increased.
- Length of time children spent in foster placement decreased.

3. Educate Service Providers on Effective Strategies

The Office of Perinatal Substance Abuse (OPSA) provides, or arranges for, technical assistance and training to alcohol and drug treatment providers that includes workshops and training events, one-on-one consultations, and manuals and other written materials.

Training also is available to professionals and public and private agencies that work with the perinatal population, such as physicians, judges, maternal child health consultants, adolescent program counselors, school districts, and county health and human services agencies.

4. Coordination and Collaboration

OPSA works closely with other State departments and constituency groups to share information and resources and avoid duplication of responsibilities. Collaborative projects focus on the following subjects:

- children's issues
- domestic violence
- education
- criminal justice
- family preservation and support
- ethnic and cultural diversity
- integrated school-linked services
- women's health and mental health issues

5. Inform the Public About the Dangers of Alcohol and Drug Use During Pregnancy

OPSA develops and makes available education, outreach, and other materials, such as research findings. To obtain a complete list, please contact the Resource Center of the California Department of Alcohol and Drug Programs at (800) 879-2772. ❐

March 1998

Fact Sheet:

The History of Perinatal Substance Abuse Services in California

1986

The Department of Alcohol and Drug Programs created the Select Committee on Perinatal Alcohol and Drug Use (first known as the Select Committee on Alcohol-Related Birth Defects) in late 1986. Its original charge was to explore the causes and impact of alcohol-related birth defects and to produce a comprehensive report with concrete recommendations that would significantly reduce this problem. The Committee convened two statewide forums that drew over 150 experts in the fields of alcohol/drug services, maternal and child health, education, and public policy. The four major recommendations resulting from these two forums were:

- establish pilot projects for comprehensive, coordinated services for pregnant and parenting women,
- conduct a statewide media campaign on perinatal alcohol and drug use,
- establish local coalitions for the prevention of perinatal alcohol and drug use, and
- provide cross training of health and social services providers.

All four of these recommendations were implemented by ADP.

1988

The Health and Welfare Agency began receiving alarming statistics regarding perinatal substance abuse from several departments under its auspices. The Department of Alcohol and Drug Programs (ADP) reported a 243 percent increase in admission requests from women for residential substance abuse treatment. The Department of Health Services (DHS) reported that under the Medi-Cal treatment program, the average cost for an infant requiring admission into a neonatal intensive care unit was $19,000, and that those costs sometimes reached as high as $1 million per episode. The Department of Developmental Services (DDS) reported that their high risk infant projects caseload increased 65 percent from the previous FY for infants affected by alcohol or other drugs. The Department of Social Services (DSS) reported that prenatal alcohol and other drug use and drug affected infants were placing an expensive burden on the foster care system.

1989

In response to these statistics, the Health and Welfare Agency established the State Interagency Task Force (SITF) to develop a coordinated state strategy to address the substance abuse treatment needs of pregnant and parenting women. The SITF was comprised of representatives from the Departments of Alcohol and Drug Programs, Social Services, Health Services, and Developmental Services.

Budget Act language provided funding for ADP in collaboration with the SITF to create the three-year *Options for Recovery Pilot Program* in the counties of San Diego, Los Angeles (two sites), Sacramento and Alameda, areas of high neonatal toxicology. Each site received $1.5 million to design and implement comprehensive substance abuse treatment programs for pregnant and parenting women and their children. The total budget act authorization for all sites each year was approximately $8 million. In the first year of the project, DSS provided funding for specialized training for foster parents, and DHS funded the case management component. In subsequent years, ADP funded these services.

ADP established technical assistance contracts to provide training to the *Options for Recovery Pilot Program*, cross training of social service agencies and alcohol and drug providers, and to develop a statewide media campaign to raise awareness regarding perinatal substance abuse. The cross trainings and media campaign were Select Committee recommendations.

Also in response to the Select Committee recommendations, ADP granted counties $10,000 by request for proposal to develop local coalitions for the prevention of perinatal alcohol and drug use. There were ten counties initially, and by 1991 there were 29

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counties in all. The grants were intended to assist community groups to launch prevention education and service coordination efforts.

1990

AB 3010 (Speier) established in statute the Office of Perinatal Substance Abuse (OPSA) and SITF. The main task of the SITF would be to continually develop and evaluate the pilot projects. The statute also designated ADP as the lead agency for the SITF.

The Options for Recovery Pilot Program was expanded to include Contra Costa County and the Regional Project (composed of Shasta, Glenn, Tehama, Siskiyou, and Butte Counties.) As with the original pilots, these sites received $1.5 million each. The total allocation for both sites each year was approximately $3 million.

OPSA staff provided extensive technical assistance to the Pilot Programs and conducted numerous site visits.

1991

Governor Pete Wilson's Perinatal Treatment Expansion Initiative increased perinatal substance abuse services for women and their children statewide. This $25 million initiative provided $15 million in state general funds (SGF) for program expansion (with an $8 million Federal/Drug Medi-Cal match), and $2 million in SGF for the landmark *Perinatal Substance Exposure Study* (PSES).

OPSA staff wrote the first set of state guidelines for perinatal programs.

1992

OPSA staff traveled statewide conducting site reviews and providing technical assistance to newly established programs. Program guidelines were revised. Reports to the Governor and the Legislature regarding the pilot projects were prepared and distributed.

1993

The Federal Substance Abuse Treatment Block Grant established the Perinatal Set-Aside, which required that 10% of the grant be used for perinatal services.

The Federal Substance Abuse Treatment Block Grant guidelines established the first federal regulations for programs serving pregnant and parenting women. Most of the standards set forth in these guidelines were already included in California's requirements for perinatal programs. OPSA revised the state perinatal guidelines to fully comply with federal regulations, to incorporate *Options for Recovery Pilot Program* components, and the Governor's Perinatal Treatment Expansion Initiative requirements. All three of these perinatal programs were now operating under the same guidelines and were called the Perinatal Services Network (PSN).

OPSA expanded its technical assistance contracts to provide service to all perinatal programs and women specific services.

The *PSES* was released to the public and garnered nationwide attention with the alarming statistic that over 69,000 newborns are prenatally exposed to alcohol and other drugs each year in California.

1994

In 1994, the OFR project ceased its pilot status and the SITF was restructured to include representatives from all areas of the state and from other state departments. ADP also ceased being the lead agency for the SITF during 1994.

Studies were initiated on dual diagnosis, children, and other issues.

Technical assistance continued for alcohol and drug programs and other related fields.

1995

Pregnant and parenting substance abuse treatment services grew from the initial pilot sites to more than 215 perinatal programs statewide. A total of 8,000 women accompanied by approximately 12,000 of their children were served at these sites in 1995. The guidelines for perinatal programs were revised to address the evolution of services over the past eight years.

1997

The Office of Perinatal Substance Abuse (OPSA) oversees a statewide network of approximately 249 publicly-funded perinatal alcohol and drug treatment programs that serve over 12,000 pregnant and parenting women accompanied by approximately 18,400 children (from birth through age 17). Programs may supplement their budgets with grants and contributions and can charge fees based on a client's ability to pay. In addition, State and federal perinatal funds support activities in research, technical assistance, collaboration and coordination, and education and outreach. ❐

STATE OF CALIFORNIA
DEPARTMENT OF
ALCOHOL AND DRUG PROGRAMS

October 1996

Fact Sheet:

The Resource Center

The Resource Center acquires information and knowledge and transfers it to California communities, organizations, alcohol and other drug programs, government, elected officials, other policy makers, families, and individuals.

Accessing and responding to individuals, programs and organizations, communities throughout the state, nationally, and internationally, the Resource Center is at the crossroads of mentoring and alcohol and other drug information and referral activity.

Information and Referral

Treatment referrals, publications, library research, mentor programs, electronic reference services, and technical information can be accessed by telephone, fax, the Internet, or in person. We make a special effort to serve individuals as well as provide information for community meetings, conferences, and workshops. Special focus is given to organizations which provide services to ethnic minorities, youth, women, older adults, people with disabilities, gays/lesbians, the homeless, or other targeted populations.

Referral to treatment and recovery services can be obtained by calling (800) 879-2772 or (800) 662-4357. The California Mentor Initiative offices can also be reached through (800) 444-3066.

Clearinghouse

Nearly 350 brochures, pamphlets, research papers, posters, program descriptions, technical manuals, and other helpful materials are available to you and your organization free of charge.

We're constantly working to produce new materials and find additional resources to meet your needs. A free publications catalog is available.

Mentor Program

The Department supports the California Mentor Initiative (CMI) by providing a centralized location for accessing mentoring programs. This program's goal is to increase societal awareness of the benefits of mentoring and the reduction of alcohol and other drug use, teen pregnancy, educational failure, and gangs and violence. Information can be obtained about recruiting and training new mentors,

creating alternative funding options, and expanding private sector participation and fiscal investment in mentor services.

The Resource Center serves as a library and clearinghouse of mentoring resources, materials, and maintains a database for mentor referrals.

Technical Assistance

Staff can help to answer inquiries about technical assistance, training, and funding information. Helping alcohol and other drug programs and organizations reduce barriers and improve services is a priority. Requests for information about ways to improve effectiveness are referred to contracted organizations or other helpful sources.

Electronic Communications

We have at our fingertips a world of information -- literally.

Electronic communications networks put us in touch with resources the world over. Our Internet homepage provides easy access to the publications catalog as well as links to mentoring programs, county alcohol and drug programs, a calendar of current training conferences and workshops, library resources, funding and grants information, and a wealth of other information. We are also a member of the Regional Alcohol and Drug Awareness Resource (RADAR) Network, a Center for Substance Abuse Prevention-sponsored program linking clearinghouses, prevention resource centers; and national, international, and local organizations that support alcohol, tobacco, and other drug reduction activities throughout the United States and abroad.

Library

The Resource Center Library maintains its own collection of reference sources. Our librarian can help you find the books, journals, reports, videotapes, or other documents you need. The library is available as well to help you with research projects and reference questions. On-line databases as well as library catalogs and Internet sources are searched to provide up-to-date reference and research support. If we don't have the titles you're looking for, we can search national databases to find them. ■

How To Reach Us

You'll find The Resource Center located at:

California Department of Alcohol and Drug Programs
1700 K Street, First Floor
Sacramento, CA 95814-4037

You can contact us at:

(800) 879-2772 (within California)
(800) 662-4357 (throughout the U.S.)
(800) 444-3066 (California Mentor Initiative)
(916) 327-3728
(916) 323-1270 FAX
(916) 445-1942 TTY

http://www.adp.cahwnet.gov

May 1997

Fact Sheet:

SB 2669

Senate Bill (SB) 2669 (Presley, Chapter 1603, Statutes of 1990) did the following:

- Added Section 11165.13 to, and amended Section 11166 of, the California Penal Code specifying that:
  - *a positive toxicology screen at the time of delivery of an infant is not, in and of itself, a sufficient basis for reporting child abuse or neglect.*
  - *a report based on risk to a child related solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to county welfare departments and not to law enforcement agencies.*
- Added Sections 10900-10902 to the Health and Safety Code mandating that:
  - *counties establish protocols among health and welfare departments and all public and private hospitals in the county to assess the need of all pregnant and birthing women and or infants for services related to substance-exposure and/or substance abuse problems.*
  - *the State develop and disseminate a model needs assessment protocol to assist in determining the level of risk to, and intervention needed for, a substance-exposed infant and to identify services needed by the mother, child or family.*
- In 1991, the *SB 2669 Model Needs Assessment Protocol* was published, developed by a committee of representatives from the State Departments of Alcohol and Drug Programs, Developmental Services, Health Services, and Social Services; and from the areas of hospital administration, public health, substance abuse prevention and treatment, and child welfare. In addition to providing guidance in identifying needed services to assist the mother in caring for her child, it offers a framework for determining the level of risk to the newborn upon release to the home and the corresponding level of services and intervention needed to protect the infant's health and safety.
- Counties could either adopt the model needs assessment protocol in its entirety or use it as a blueprint for developing their own protocols. Because no funds were provided for the activities required by SB 2669, many counties have filed claims, and been reimbursed by the Commission

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on State Mandates, for the development and dissemination of their county's protocol.

- In 1992 and 1994, the Western Consortium for Public Health evaluated the effectiveness of the implementation of SB 2669 and found a number of critical shortcomings.

  - *In 1992, 34 of 49 counties surveyed had completed the development of protocols; however, the majority of counties responded that the implementation of protocol use by hospitals was inconsistent. Lack of funds, liability concerns, and resistance among private physicians whose clientele are primarily white and middle-class were some of the reasons mentioned. Most counties reported that referrals to child protective services and alcohol and other drug treatment services had either remained the same or had increased since SB 2669 went into effect.* [1]

  - *In 1994, hospital perinatal nurse managers were surveyed as well as county social and health services personnel. The findings confirmed earlier results of irregular utilization of protocols. While 69% of the responding counties had protocols that would identify perinatal substance exposure, only 33% of the counties indicated their hospitals routinely followed the protocol guidelines. It also indicated that 50% of hospital nurse-managers believed that substance abuse treatment resources were not available for women giving birth in their communities. In addition, the study indicated that screening and assessment is more thorough and consistent in public hospitals than in private.* [2]

- In 1997, the Governor's Infant Health and Protection Initiative (IHPI) was proposed to address the problems associated with hospital assessments and county protocols, to reduce the frequency and severity of child abuse and neglect by substance-abusing parents and enhance protections for vulnerable infants and toddlers. The IHPI will make hospitals' compliance with SB 2669 a condition of licensure and expand perinatal treatment services to serve the substance-abusing families referred through the in-hospital assessment.

For more information regarding SB 2669 policies, please call the Program Operations Division (POD) at (916) 323-4445. ❐

1 Noble, A. (1992). *Efforts to Identify and Assess the Needs of Substance-Using Delivering Women: The Implementation of Senate Bill 2669 in California's Counties.* Department of Alcohol and Drug Programs.

2 Klein, D., Crim, D., and Azhnd, E. (1994). *An Analysis of California's Emerging Systems for Assessing the Needs of and Intervening with Substance-Using Perinatal Women.* Department of Alcohol and Drug Programs.

November 1997

Fact Sheet:

Social Model Recovery

The social model of alcohol and drug recovery in California has evolved through several generations to what we know as the model of the 90's. Social model programs emphasize the process of learning through ''doing'' and ''experiencing'' and providing positive role models. Social model programs are extremely cost effective and are extremely outcome effective because of their ability to build strong and lasting social support systems.

The roots of modern social model are in the mutual self-help concepts of Alcoholics Anonymous. Individuals struggling with early sobriety often were temporarily homeless and in need of social support systems. Members of Alcoholics Anonymous would often house newer members and act as guides by sharing their own experiences. Since Alcoholics Anonymous, according to its ''Traditions,'' could not be involved in support systems, it became a movement of its own. When public support began to flow into these recovery homes, they became more formalized with program standards and facility licensing.

An example of social model includes Recovery Homes, which are a community-based, peer group oriented, residential facilities that provide food, shelter, and recovery services in a supportive, nondrinking, drug-free environment. Services provided include individual and group recovery planning, alcohol and drug recovery education, group support, recreational activities, assistance in obtaining health, social, vocational and other community services.

Typically, the home is cheerful, warm and accepting, and provides an environment in which the recovering alcoholic or addict has the opportunity to make a positive change in lifestyle with an alcohol and drug free environment and positive role models.

The major goal of a recovery home is to provide an environment in which men and women recovering from alcoholism and drug addiction will experience a sober, functioning lifestyle, and return to the community as a responsible drug-free individual.

A nonresidential Social Model Program is a community-based program that provides a sober supportive environment, offers services to persons with alcohol or drug related problems, and educates the surrounding community concerning such problems in order to reduce alcohol or drug related problems including alcoholism or drug addiction. ❐

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Social Model:

The Most Frequently Asked Questions

What is the social model of recovery in California?

The roots of modern social model recovery are in the mutual self-help concepts of Alcoholics Anonymous. Programs emphasize the process of learning through ''doing'' and ''experiencing,'' and by providing positive role models.

What is an example of social model?

A Recovery Home is a community based, peer-group oriented, residential facility that provides food, shelter, and recovery services in a supportive, nondrinking, drug-free environment.

What types of services are provided?

Individual and group recovery planning, alcohol and drug recovery education, group support, recreational activities, information about and assistance in obtaining health, social, vocational and other community services are offered.

What is the major goal of a recovery home?

The major goal is to provide an environment in which men and women recovering from alcoholism or drug addiction will experience a sober, functioning life style and return to the community as a responsible drug-free individual.

Are social model programs residential only?

No, there are also nonresidential social model programs. These are community based programs that provide a sober supportive environment, offer services to persons with alcohol-related problems and educates the surrounding community concerning such problems.

Where can I obtain further information on social model programs?

The following are private organizations that may be contacted for further information:

- California Association of Addiction Recovery Resources
  (916) 338-9460

- Social Model Recovery Systems
  (626) 332-3145

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October 1996

Fact Sheet:

Treatment Programs For Specific Populations

BACKGROUND

Through the aegis of both the local and State levels, services for specific populations are provided.

Through the Substance Abuse Prevention and Treatment (SAPT) Block Grant, county alcohol and drug program administrations provide, or subcontract, services to specific populations. Taking into account the unique composition of each county and its needs, the local administration and its Board of Supervisors determine how best to expend SAPT funds at the county level.

At the State level, the Department of Alcohol and Drug Programs (ADP) authorizes, provides, and monitors services to a variety of specific populations within the State. These specific populations include:

- ethnic and minority groups;
- criminal justice populations;
- women and children;
- homeless and homeless youth;
- individuals who are vulnerable to the human immunodeficiency virus (HIV); and
- residents of rural areas of California.

Through the Information Management Services Division and its technical assistance contractors, technical assistance and training are provided to improve services and provide increased accessibility for at-risk populations at no cost to the requesting agency. Consultation, staff and community training, workshops and seminars, and newsletters regarding the following areas are provided:

- Aging Populations
- African Americans;
- Alcohol and Other Drug prevention programs;
- Asians and Pacific Islanders;
- Chicanos/Latinos;
- Gays and Lesbians;
- Native Americans;
- People with Disabilities;
- Women and Perinatal Issues; and
- Women's Case Management and Professional Training.

ETHNIC AND MINORITY GROUPS

The Center for Substance Abuse Treatment (CSAT) awarded Critical Populations discretionary grants to ADP for targeted specific populations which include ethnic and minority groups. There are culturally competent and linguistically appropriate treatment programs targeted for African-Americans, Asian and Pacific Islanders, Latinos, and Native American populations.

At the State level, under Senate Bill (SB) 2382, three pilot projects target prevention and non-residential treatment of alcohol and drug abuse in Asian and Pacific Islander (API) communities. Culturally and ethnically specific Drinking Under the Influence services, prevention and non-residential treatment services, and bilingual and bicultural alcohol and drug treatment services for the API communities are provided in San Francisco, San Joaquin, and Los Angeles counties. All projects are funded at approximately $100,000 per year. ADP contracted with the University of California, Los Angeles, Drug Abuse Research Center, to design and conduct an eighteen month evaluation of these projects. ADP will use the results to determine if these projects are meeting the

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needs of this diverse population. Evaluation funding for this Fiscal Year (FY) is $125,000.

CRIMINAL JUSTICE POPULATIONS

The Department, through several funding sources such as CSAT discretionary grants and cooperative agreements, the SAPT Block Grant, and State General Funds, has created linkages between the substance abuse treatment and the criminal justice systems. To assure maximum accessibility, ADP provides services through a variety of administrative mechanisms, such as inter-agency agreements, cooperative agreements, and Negotiated Net Amount contracts, and within various environments, such as state prisons, county jails, and local communities. Projects funded by an annual appropriation of $14,124,000 include:

- Parolee Services Networks;
- Incarcerated/Non-incarcerated Treatment Programs;
- Female Offender Treatment Project;
- Target Cities Project;
- Criminal Justice Treatment Network for Women; and
- Adolescent/Juvenile Justice grants.

WOMEN AND CHILDREN

Within ADP, services to women and children are provided through a variety of means. The Children, Youth, Families & Communities (CYFC) Division oversees a number of projects for this population. For example, SB 3010 implements a statewide network of comprehensive perinatal alcohol and drug treatment programs to serve approximately 9,000 women and 12,000 children, birth through age 17, annually.

CYFC works closely with other State Departments and interested groups to share information and resources to collaborate on shared concerns such as children's issues, domestic violence, family preservation and support, integrated school-linked services, and women's health and mental health issues.

Within the Program Operations Division, ADP monitors CSAT discretionary grants which include those designed to expand the availability of high quality residential treatment services for women who suffer from alcohol and other drug use problems.

Totaling $9.2 million annually, the Pregnant and Postpartum Women and the Residential Women and Children's discretionary grants fund ten programs throughout the State. Services are provided to approximately 350 substance abusing women and 550 children each year.

HOMELESS AND HOMELESS YOUTH

There is a four year project in Alameda County to study the impact of community-based homeless service plans that combine housing with drug and mental health treatment, job training, and other needed services for homeless men and women returning to social and economic mainstream lifestyles.

FY 1995-96 funding for the second year of this outcome study is $110,000.

Assembly Bill 3550 established Homeless Youth Projects with ADP working with the Office of Criminal Justice Planning. Beginning in 1995, and continuing through FY 1996-97, SAPT Block Grant funds are allocated to Los Angeles and San Francisco to operate outreach programs targeting substance abuse problems of substance-dependent homeless youth. Services include intervention, assessment, counseling, treatment, and referral to detoxification and rehabilitation programs. FY 1995-96 funding is $250,000.

INDIVIDUALS VULNERABLE FOR THE HIV VIRUS

CSAT funded one California provider to support outreach services to substance abusers and their sexual partners who are at highest risk for HIV, sexually transmitted diseases, and tuberculosis. In the second year, Prototypes, Los Angeles, received funding in the amount of $309,876 in this category.

RESIDENTS OF RURAL AREAS

To treat populations located in California's rural areas, CSAT awarded grants to a consortium of Butte, Plumas, and Tehama counties and to Lassen County in the Critical Populations discretionary grant category.❐

February 1998

Fact Sheet:

Substance Abuse Prevention and Treatment (SAPT) Block Grant

Overview

ADP is the state agency responsible for planning, carrying out and evaluating services and activities funded through the federal Substance Abuse Prevention and Treatment Block Grant. Block grant funds are allocated to counties for local substance abuse prevention and treatment programs, and to fund special projects.

How to Apply

Eligibility to apply for block grant funds is limited to states and U. S. territories. States must submit an application to the Center for Substance Abuse Treatment by September 1 of each year in order to receive funds in the next federal fiscal year (October 1 to September 30).

Determination of Funds Available

Each year the U.S. Congress determines the total appropriation to be allocated. For Federal Fiscal Year 1997, California received $181,870,785.

In order to receive funding, states must demonstrate a ''maintenance of effort'' by maintaining ongoing, nonfederal expenditures at least equal to the average expenditures for the two years preceding the federal fiscal year for which states are applying.

States must also demonstrate ''material compliance'' with program requirements. If states fail to meet this requirement, as determined by the federal government, a grant for a subsequent year may be reduced by an amount equal to the compliance deficiency.

Disbursement of Funds by the State

Funds are allocated to California's 58 counties using an allocation methodology based on population and need factors. The money is awarded through a Negotiated Net Amount contract process.

Terms and Conditions for Use of Funds

Block grant funds are only to be used for alcohol and other drug treatment and prevention. The ADP provides a wide range of services and activities to address the abuse of alcohol, as well as the use and abuse of licit and illicit drugs and tobacco products.

States are required to expend funds for the following specific purposes:

- Alcohol prevention and treatment - 35%
- Other drug prevention and treatment - 35%
- Primary prevention - 20%
- Intravenous drug use activities and services
- HIV early intervention services for persons already in alcohol and drug treatment - 5%
- Treatment services for pregnant women and women with dependent children
- A revolving fund for the establishment of group homes for recovering abusers of alcohol and other drugs.

States administrative costs may not exceed 5 percent of the total allocation.

States may not expend block grant funds for the following:

- Inpatient hospital substance abuse programs, except when such treatment is a medical necessity and the individual cannot be treated in a community-based, non-hospital, residential treatment program.
- To make cash payments to recipients.
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment.
- To provide financial assistance to any entity other than a public or nonprofit private entity.
- To provide individuals with hypodermic needles or syringes.

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- Primary prevention activities - 20%
- Activities relating to intravenous drug use (IVDU)
- TB services and referral
- Early intervention services for HIV - 5%
- Treatment services for pregnant women and women with dependent children
- Revolving fund for the establishment of group homes for recovering users of alcohol and drugs

- States cannot expend more than 5 percent of Block Grant funds to pay the costs of administering the grant.

- Restrictions: Block Grant funds must not be expended:
  - For inpatient hospital substance abuse programs, except when such treatment is a medical necessity for the individual involved and the individual cannot be effectively treated in a community-based, nonhospital, residential treatment program.
  - To make cash payments to intended recipients.
  - To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment.
  - To provide financial assistance to any entity other than a public or nonprofit private entity.
  - To provide individuals with hypodermic needles or syringes.

- States must demonstrate ''material compliance'' with program requirements. If a state fails to maintain material compliance, which is determined by federal government, the amount of the allotment for the fiscal year for which the grant is being made may be *reduced* by an amount equal to the amount constituting such failure.

- SAPT Block Grant funds are allocated to California's 58 counties through a population based allocation methodology and administered through the Negotiated Net Amount contract process.

- SAPT Block Grant funds are applied for on a yearly basis. Applications must be submitted to CSAT on or before September 1 of the fiscal year prior to which the State is applying for funds (i.e., September 1, 1997 for Federal Fiscal Year 1998). The term ''fiscal year'' applies to the Federal Fiscal Year which is October 1 to September 30. ❐

November 1997

Fact Sheet:

The Therapeutic Community

The Therapeutic Community (TC) is a highly structured and well-supervised program designed to treat the behavioral, emotional, and family issues of substance abusers. The TC emphasizes abstinence from drugs, self-help, personal growth, peer support, social responsibility, and moral development.

People in a TC are members of an extended family, not patients in an institution. The heart of the TC is an environment where services are provided in a series of phases from Orientation to Aftercare. Some TCs include residential, day treatment, outpatient, and adolescent programs. There are long-term and short-term TCs. The length of treatment varies from thirty days to two years.

Within the TC, all of the household tasks, groups, individual counseling and educational seminars promote personal responsibility and emotional growth. All activities are part of an integrated set of experiences, in which members examine themselves in a context of mutual support. Peer pressure is utilized as a catalyst to convert criticism and feedback into personal insight and behavioral change.

Members of the TC earn status and privileges through demonstrations of responsibility and self-help. Members play a significant role in managing the community, and acting as positive role models for other members to emulate.

For many members, a stay in a TC is their first positive experience of belonging in a family. In the daily process of working and growing together, members learn to trust others, develop self-esteem, and construct a productive, substance-free lifestyle.

The essential elements of a TC are: behavioral limits and sanctions, role modeling, confrontations, self-help, mutual support, peer pressure, counseling, education, personal and community responsibility, vocational training, group process, and reentry into the larger community.

Today, the TC has developed special programs to meet the needs of special populations, including women with children, ethnic minorities, individuals with a Dual Diagnosis of mental illness in addition to substance abuse, young adults, people with HIV/AIDS, homeless people, and those referred from the criminal justice system. In the future, the TC will continue to adapt to meet society's needs.

There are over one thousand TCs in the United States, with facilities ranging from 6 to 100 beds. The TC is a worldwide movement, represented by the World Federation of Therapeutic Communities. In California, TCs are represented by California Therapeutic Communities (CTC). ❐

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The Therapeutic Community:

The Most Frequently Asked Questions

What is a therapeutic community (TC)?

It is a well-supervised program which emphasizes abstinence from alcohol and other drugs, self-help, personal growth, and peer support. The Department licenses residential TCs as nonmedical alcoholism or drug abuse treatment facilities. TCs may also be certified if they request and meet Department certification standards.

Who are served by therapeutic communities?

Therapeutic communities are highly-structured and well-supervised programs designed to treat the behavioral, emotional, and family issues of adult and adolescent substance abusers.

What takes place in a therapeutic community?

People in a TC are members of an extended family, not patients in an institution. Essential elements are: behavioral limits and sanctions, role modeling, confrontations, self-help, mutual support, peer pressure, counseling, education, vocational training, group process, and reentry into the larger community.

How long does a person stay in a TC?

There are both long- and short-term TCs. The length of residential treatment varies from thirty days to two years.

What positive impact do TCs give to members?

For many, a stay in a TC is their first positive experience of belonging in a family. Members learn to trust others, develop self-esteem, and construct a productive, substance-free lifestyle.

Where are TCs located?

There are over one thousand TCs in the United States, 25 being in California. The facilities range in size from six to 100 beds.

How are TCs reimbursed for services provided?

There are various methods by which TCs receive payment for services. Individuals may pay with personal resources or their services may be covered by insurance. Counties contract with TCs to provide services to indigents. Other sources include State disability insurance, scholarship beds funded by private donations, and adolescent programs funded through group home fees.

Where can I obtain more information on the Therapeutic Communities?

Contact Elizabeth Stanley-Salazar, c/o Phoenix House, Inc., 11600 Eldridge Avenue, Lake View Terrace, CA 91342.

February 1997

Fact Sheet:

Tobacco Sales to Minors [The Synar Amendment]

Section 1926 of the federal Public Health Services Act of 1992 requires States to pass and enforce a State law which prohibits the sale and distribution of tobacco products to individuals under 18 years of age, and requires random, unannounced inspections to ensure compliance with State law. This federal law is entitled the Synar Amendment, after the U.S. Senator who introduced and heavily supported this legislation. The Synar Amendment is a condition of funding for States receiving the Substance Abuse Prevention and Treatment (SAPT) block grant. Although California law prohibits the sale of tobacco products to minors (Penal Code Section 308; statutes of 1981), the law was not sufficient to meet the enforcement requirements of the Synar Amendment. In response to federal statute, the California Legislature passed the STAKE Act (Stop Tobacco Access to Kids Enforcement Act, Chapter 1009, Statutes of 1994) .

The STAKE Act mandates the following ongoing activities:

- The California Department of Health Services (DHS) shall implement an enforcement program to reduce the illegal sale of tobacco products to minors and conduct compliance checks using minors granted immunity.
- Tobacco retailers shall post a warning sign at each point-of-purchase that includes a toll-free number to report violations.
- DHS shall develop regulations regarding the sign and enforcement activities.
- Retail clerks shall check the identification of youthful-appearing persons prior to a tobacco sale.
- Assessments of civil penalties ranging from $200 to $6,000 against store owners for violations.
- Tobacco wholesalers, distributors, and vending machine operators shall provide a list to DHS of all tobacco vendor names and locations.
- An annual report shall be prepared by DHS regarding enforcement activities and their effectiveness.

The Department of Alcohol and Drug Programs (ADP) transfers $2 million dollars to DHS each year from the SAPT block grant to implement the provisions of the Synar Amendment. Activities completed to date include:

- Statewide technical assistance and training for local community groups.
- A scientific, baseline survey of unannounced inspections of tobacco vendors.
- Completion of emergency regulations governing the program.
- Implementation of compliance checks of tobacco vendors.
- An extensive merchant education campaign.
- Creation of a toll-free number (1-800-5-ASK-4-ID) which can be called to report illegal sales of tobacco products to minors. DHS estimates that they have received approximately 18,075 calls since implementation of the toll-free number in October, 1995.

ADP is also accountable to the federal Substance Abuse and Mental Health Administration regarding compliance with Synar Amendment requirements and includes this information in the annual SAPT block grant application. Failure to meet the terms and conditions of the Synar Amendment could result in substantial reductions in the amount of SAPT grant funds allotted to California for alcohol and other drug prevention and treatment programs. ❐

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November 1997

Fact Sheet:

U.S.-Mexico Border Substance Abuse Initiative

Based on extensive experience in prevention and treatment of alcohol, tobacco, and other drug use (ATOD), the California Department of Alcohol and Drug Programs (ADP), in collaboration with the Imperial County Department of Mental Health Services-Alcohol and Drug Programs and the San Diego County Department of Health Services-Alcohol and Drug Services, applied for and was awarded a one-year $396,000 federal grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration in September 1997. The U.S.-Mexico Border Substance Abuse Initiative is a program to strengthen and promote substance abuse prevention efforts for youth, children, parents, families, schools, and the faith community in the United States southwest border region. Implementation of the U.S.-Mexico Border Initiative within communities that are within 60 miles of the California-Mexico border in Imperial and San Diego Counties will achieve improved coordination and leveraging of federal, state, and community-level prevention efforts. It will encourage increased collaboration among state and local organizations along the border and with prevention counterparts in Mexico. Representatives from these Counties and ADP will participate in periodic meetings with representatives of the other grant recipient states of Arizona, New Mexico, and Texas to exchange relevant information on border-related issues. They will also participate in the Binational U.S.-Mexico Demand Reduction Conference to be held during federal fiscal year 1998.

The State of California's implementation of the U.S.-Mexico Border Substance Abuse Initiative will allow the border communities in Imperial and San Diego Counties to combat the unique and diverse ATOD problems that stem from their proximity to the border with Mexico. ADP, the county government representatives, the subrecipients, and the technical assistant advisors will work closely to:

1. Implement the state project plan that identifies concrete actions to achieve the objectives within the organizational and procedural framework of the Initiative;

2. Implement an alcohol and other drug prevention framework using the principles of multiple-level collaboration and community engagement;

3. Link county initiatives, implemented by partnerships between public systems, including health, social services, schools, criminal justice agencies, and private community-based systems;

4. Evaluate and measure outcomes and to share data and information across projects;

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5. Implement activities and services that will sustain prevention efforts following the end of the federal grant period; and

6. Work cooperatively with the State Border Health Desks to ensure that the most appropriate subrecipient communities will receive these limited grant funds.

This comprehensive approach provides a realistic vehicle for achieving the objectives of the Initiative by:

- reducing the incidence of physical violence by, or against, adolescents;
- reducing the rate of teen pregnancies;
- reducing the rate of school drop-outs;
- reducing sales of alcohol and tobacco to minors; and
- increasing the ability of parents to effectively address ATOD issues with their children.

The outcomes of the State's Project will support family enrichment and/or awareness programs, school-based peer support services, mentoring, and youth-directed activities. The purposes of California's State Project will be to:

- support and facilitate federal, state, and community-level substance abuse prevention efforts for youth, parents, families, schools, the workplace, and the faith community;
- encourage and develop methods for greater collaboration among the numerous state and local organizations working within the border communities;
- to strengthen and/or develop binational efforts to combat substance abuse with our counterparts in Mexico;
- develop the California-Mexico Substance Abuse Prevention Education & Training Plan specific to the local border region;
- provide a Binational Bilingual Media Literacy Campaign;
- provide Substance Abuse Prevention Media Outreach and Communication Campaigns;
- establish a binational collaborative committee to develop coordinated substance abuse prevention strategies;
- provide professional cross-education and training; and
- increase access to substance abuse prevention programs through coordination and integration of a comprehensive continuum of care.

For more information regarding California's implementation of the U.S.-Mexico Border Substance Abuse Initiative, please call Margaret Cossey in the ADP Prevention Network Section at (916) 324-4468. ❐

February 1997

Fact Sheet:

Drug Free Work Place Recognition & Services

Overview

The Drug-Free Work Place program was established by the Department of Alcohol and Drug Programs (ADP) to assist California employers in understanding and implementing the requirements of the 1990 California Drug-Free Work Place (DFWP) Act. DFWP is defined as a comprehensive program, designed to sustain a work place free from the abuse or illegal use of alcohol and other drugs. This includes the illegal use or misuse of prescription drugs. ADP's DFWP program is intended to attain extensive, voluntary employer adoption of DFWP policies and practices throughout the State of California.

Goals

1. Expand DFWP participation amongst employers throughout the state.

2. Engage professional, trade, and other associations in promoting DFWP to their memberships.

3. Establish a uniform method for recognizing the DFWP commitment of individual employers.

4. Establish and maintain an information service to assist employers and communities with general DFWP information and materials.

5. Operate a data base to track, assess, and document results, including information services, promotional efforts, and the number of employers who implement DFWP programs.

DFWP Activities

Within the CMI Division, ADP administers a contract for DFWP activities which includes outreach, education, and information programs to increase public awareness and inform employers of the potential impact of employees' drug and alcohol use. Services, such as speakers, literature, a newsletter, sample documents, trainer workshops and a toll-free telephone helpline, provide current and consistent information. This information is available to employers, attorneys, consultants, contract bidders, individual employees and their family members regarding DFWP policy issues, drug testing, and employee assistance programs.

ADP's contractor also administers a recognition program for employers who commit to adopting DFWP policies and creating a DFWP environment. Employers who make such a commitment are provided a California DFWP decal and an ADP DFWP proclamation. To qualify for this recognition, a business must have a DFWP policy in place, train supervisors and employees regarding this policy, and know how to access, provide assistance for and/or refer an employee with a drug/alcohol problem.

For more information regarding DFWP policies and programs, please call CMI at (800) 444-3066, or the toll-free California DFWP helpline at (888) 661-0444. ❐

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December 1996

Fact Sheet:

California's Youth Pilot Program (Assembly Bill 1741)

Summary

In 1993, the Legislature passed and Governor Pete Wilson signed AB 1741 (Chapter 951, Statutes of 1993), establishing the Youth Pilot Program (''Youth Pilot''). As amended through the 1995 legislative session, the Youth Pilot's enabling legislation established it as a six-year program, authorizing six California counties to blend various children and family services funds to support implementation of innovative strategies at the local level to provide comprehensive, integrated services to children and families. Selected through a competitive process, the six pilot counties are Alameda, Contra Costa, Fresno, Marin, Placer and San Diego.

The Youth Pilot places a strong emphasis on local planning and decision making as to the best use of human service funds to support the integration of services. To help shape this locally-driven process, AB 1741 required each selected county to conduct a community needs assessment involving consumers and providers, to better understand the specific needs of the target populations or geographic areas to be served by the pilot program. County boards of supervisors were required to establish broad-based, collaborative structures (coordinating councils) to facilitate the development of shared visions and goals designed to meet identified community needs.

Membership of each coordinating council must, at a minimum, include local officials from the fields of education, juvenile justice, and health and human services, as well as representative s of service providers, labor organizations, and service recipients. County coordinating councils are responsible for developing plans for implementing the pilot in their respective cities, designing strategies for meeting their community needs through blended funding, integrated services and innovative programs. Blended funds, which may include public and private monies, must support services to high-risk, low income, multi-problem youth and families. It's important to note that AB 1741 did not appropriate any new funding for the pilot counties. Instead, the bill provided for the blending of some or all funds from a broadly defined list of categorical program funds.

To measure the effectiveness of local programs in achieving established goals and meeting identified community needs, each coordinating council, with community involvement, has selected specific outcomes, to be monitored throughout the term of the pilot. These outcomes must be supported by logical, reliable and measurable indicators.

Ultimately, the Youth Pilot Program may provide models for the implementation of service delivery systems that are locally-controlled, family-focused, prevention-oriented and outcome-based.

The State's Role

The State's role in implementing the Youth Pilot Program is to assist each of the six selected counties in achieving its goals. To fulfill this role, the State is to provide technical assistance and facilitate application for federal waivers, when necessary and feasible. The Health and Welfare Agency, as the Governor's designee, is responsible for overseeing and coordinating state efforts. The Department of Alcohol and Drug Programs serves on the State Team for Partnership Policy, the AB 1741 Workgroup, and it has been a co-leader on AB 1741 evaluation efforts. ❐

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